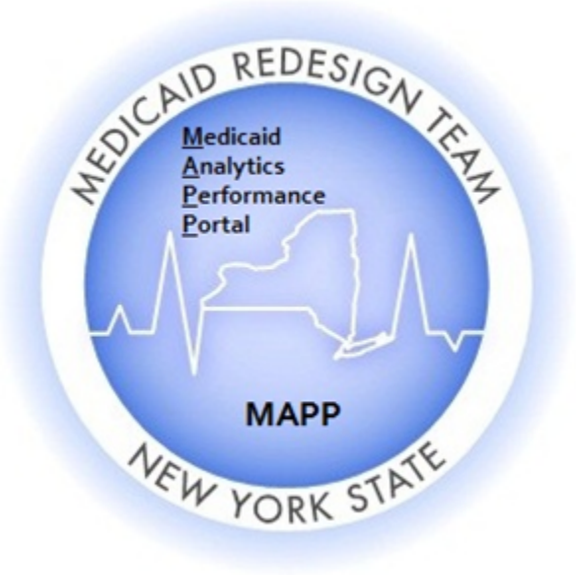
New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP PPS Organizational Application



Finger Lakes PPS

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

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

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

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

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

Currently Uploaded File: **9_SEC000_FInancial Stability - COMPLETE.pdf**

Description of File

Financial Stability Tests for URMC and RRHS

File Uploaded By: rghcfish
File Uploaded On: 12/20/2014 10:11 AM

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

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

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

Last Updated By: rghcfish
Last Updated On: 12/22/2014 09:43 AM

Certified By: rghcfish
Certified On: 12/22/2014 09:45 AM
Lead Representative: Carol Fisher

Unlocked By:
Unlocked On:

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SECTION 1 – EXECUTIVE SUMMARY:

Section 1.0 - Executive Summary - Description:

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

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

Section 1.1 - Executive Summary:

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

#	Goal	Reason For Goal
1	Improve health through system reforms, prevention, early detection, and delivery of integrated care	The FLPPS CNA data provides evidence that the regional health care delivery system currently operates in silos with poor care transitions and a disconnected Information Technology (IT) infrastructure that limits the ability to identify of at-risk patients, and track patients across the care continuum. A lack of coordination between primary care and behavioral health providers, who serve the PPS' most vulnerable consumers including those with co-morbid conditions, shows a need for integration of clinical, behavioral and social supports to promote population health and system improvement.
2	Provide patient-centered, appropriate care through health literacy and provider sensitivity	CNA data identified gaps in patients' understanding of disease processes, appropriate service use and self-care for chronic conditions. FLPPS will focus on engaging patients in prevention and disease management through the facilitation of enhanced health literacy, and increased provider sensitivity to strength-based patient-centered needs. Stakeholder input supports the need to "meet patients where they are", and leverage linkages with Community-Based Organizations (CBOs) to promote cultural competence in service delivery. The PPS will address this gap through centralized strategies and services, as well as distributed expansion of provider capacity and capital investments to enhance health literacy and ensure cultural competence across the region.
3	Increase access to primary care to ensure the right care is delivered at the right place and time	FLPPS is the largest, most geographically diverse PPS in NY State, with a mix of urban and rural sub-populations. The CNA identified significant gaps in access to primary care resulting in high PPVs, PPRs, and PQI admissions. The PPS selected projects that include a focus on reducing unnecessary re-admissions and emergency department use in particular.

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

In order to transform the care delivery system and meet the needs of the community, FLPSS includes strong leadership supported by an accountable governance organization. FLPPS is challenged by a geographically expansive service area, which includes both urban and rural counties. Centralized systems and a highly competent management team are complemented by the expertise of providers and agencies working across the region's urban center and four rural Naturally Occurring Care Networks (NOCNs). This allows FLPPS to leverage the strength of its tertiary medical centers and address the diverse needs of providers and patients across the large and diverse region. FLPPS membership includes a broad, comprehensive continuum of providers, as well as CBOs and other partners. A thorough CNA was developed by Finger Lakes Health Services Agency (FLHSA), which included essential input from a diverse range of regional

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stakeholders. This analysis was used by the PPS to identify opportunities for systematic improvement, provide the foundation for the selection of 11 DSRIP projects, and facilitate greater collaboration between urban and rural partners.

***Steps:**

Provide the vision of what the delivery system will look like after 5 years and how the full PPS system will be sustainable into future.

In five years, the population served by FLPPS will have access to a fully integrated delivery system that promotes physical health, behavioral health and social supports, facilitated by an IT infrastructure that serves and integrates the continuum of care. This delivery system will be patient-centered, value-based, and culturally, linguistically and ethnically accessible. FLPPS will feature partnerships between healthcare providers, MCOs and CBOs, and include shared IT that can facilitate a population-based approach to managing health. Patients will be more engaged and better understand their health conditions. Case managers will assist those needing additional support to ensure appropriate screening, early receipt of services and adequate follow-up. The delivery system will value prevention and ensure widespread access to integrated primary and behavioral health care in Patient Centered Medical Homes. FLPPS believes that the work conducted to date and the strategies outlined in this proposal will ultimately lead to a PPS that truly attends to the needs of the population through the provision of high value services - resulting in improved outcomes and financial sustainability.

***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	18 NYCRR Section 505.10(c) ambulette & nonemergency ambulance transportation (d) prior authorization	This regulatory waiver will primarily impact projects 2.a.i Create an Integrated Delivery System focused on Evidence-Based Medicine and Population, 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, and 3.f.i Increase Support Programs for Maternal and Child Health (Including High-Risk Pregnancies). The common component among these programs is transportation of patients to needed services, including uninsured not currently covered under this regulation. A waiver would address: a) Restrictions on destinations. Destinations that may benefit a DSRIP program participant but are not currently eligible; for example, trips to pharmacies, grocery stores, etc., b) Limiting use to regulated carriers. Community transportation providers that may have seating capacity, but which are not approved and regulated vendors; for example, a local ARC program could ride share PPS participants, c) Freedom of choice requirement under fee for service. Waiving this

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#	Regulatory Relief(RR)	RR Response
		requirement would permit PPS to designate which carrier a recipient must use to create efficient routing, d) Taxi rates & mileage reimbursement rules. The current methodology limits mileage reimbursement to one passenger per group. The alternative has been to identify private pay for Taxi services, but these services are not regulated and generally cost prohibitive. This request necessitates the PPS establish robust protocols, subject to review & approval, and complete ongoing patient safety audits while allowing the PPS to expand the definition of the "site of care" to include resources and other mechanisms to augment transportation services that are not currently covered under traditional transportation services.
2	10 NYCRR Part 401.2 (b) Limitations of Operating Certificates	This regulatory waiver will primarily impact projects 2.a.i Create an Integrated Delivery System focused on Evidence-Based Medicine and Population, 2.b.ii. Transitional Supportive Housing Services, 3.a.i. Integration of Behavioral Health and Primary Care Services. The common component among these programs is the need to minimize barriers to patient care, which may include venue of care, rapid access to care, and patient service in a safe setting. A waiver would address: a) the ability to assess individuals in their home verses a clinical setting when appropriate. Many individuals need supports in their home to achieve increased independence and remain in the community, b) the current regulation which impedes our ability for professionals other than nurses and physicians to see a patient immediately after hospital discharge, c) the cost for medical transportation for individuals who are not able to access services outside the home independently. PPS policies and procedures will define mental health and substance abuse clinical roles, qualifications, orientation, practice and documentation standards and clinical supervision and quality evaluation and monitoring for all mental health and substance abuse clinicians embedded in DSRIP projects including an organizational leadership and quality oversight structure for mental health and substance abuse clinicians embedded in DSRIP project sites. Protocols for ongoing audits will be established to monitor patient safety concerns. Policies and procedures will be consistent with The Joint Commission standards regarding human resources, competency assessment, credentialing, privileging etc. It is likely that waiver of this regulation, particularly with respect to transitional supportive housing, will enhance patient safety by re-defining "home" and expand the definition of the "professional".
3	10 NYCRR 401.3 Changes in existing medical facilities	This regulatory waiver will primarily impact projects 2.b.ii. Transitional Supportive Housing Services, 3.a.v.Behavioral Interventions Paradigm (BIP) in Nursing Homes. The common component among these programs is the need to provide an expedited and flexible means for current facilities to repurpose design; in order to add or modify services while maintaining DOH safety codes. A waiver would address: a) the need to modify current facility design to contain and/or separate behavioral health services, b) the enablement of rapid implementation of changes as dictated by changing community needs; primarily through the expedition of lengthy State approval cycles. This relief is an alternative to seeking a waiver for tele-health services or the need to transport patients to a different site which introduces a challenge given the scarcity of transportation services in the region. PPS policies and procedures will define mental health and substance abuse

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#	Regulatory Relief(RR)	RR Response
		clinical roles, qualifications, orientation, practice and documentation standards and clinical supervision and quality evaluation and monitoring for all mental health and substance abuse clinicians embedded in DSRIP projects, including an organizational leadership and quality oversight structure for mental health and substance abuse clinicians embedded in DSRIP project sites. Policies and procedures will be consistent with Joint Commission standards regarding human resources, competency assessment, credentialing, privileging etc. It is likely that waiver of this regulation will enhance patient safety.
4	14 NYCRR Part 599 Clinic Treatment Programs	This part establishes standards for the certification, operation and reimbursement of mental health clinic treatment programs serving adults and children. It presupposes that a patient is admitted into a specialty episode of care with specific requirements for admission, discharge, treatment planning, and a limit on other services provided in a mental health clinic treatment program. The regulatory waiver will primarily impact projects 3.a.i. Integration of Behavioral Health and Primary Care Services, 3.a.ii. Behavioral Health Community Crisis Stabilization Services, 4.a.iii. Strengthen Mental Health and Substance Abuse Infrastructure Across Systems. The common component across these projects is to provide increased services with currently limited resources. A waiver would address a) enhancement of DSRIP models that seek to provide episodic mental health care and treatment for persons present in non-mental medical health settings who require mental health and crisis stabilization, while attempting to link them, as appropriate and indicated, to more intensive psychiatric care, or patients who are in non-behavioral health system (PCP) and need episodic care from a mental health and substance abuse provider, b) the incorporation of peer-to-peer services within the clinic services, c) the ability of FQHCs and Article 28 clinics to offer more than the 10,000 annual service level cap currently in place. Alternatively, without this waiver, services will likely remain in siloes while transportation services are attempted to be improved. PPS policies and procedures will define mental health and substance abuse clinical roles, qualifications, orientation, practice and documentation standards and clinical supervision and quality evaluation and monitoring for all mental health and substance abuse clinicians embedded in DSRIP projects including an organization leadership and quality oversight structure for mental health and substance abuse clinicians embedded in DSRIP project sites. Policies and procedures will be consistent with Joint Commission standards regarding human resources, competency assessment, credentialing, privileging etc. Patient safety is a key focus of the PPS thus regular audits will be conducted to address potentially unforeseen safety concerns.
5	14 NYCRR Part822 General Service Stds for Chemical Dependence Outpatient & Opioid Treatment Programs	This regulatory waiver will primarily impact projects 3.a.i. Integration of Behavioral Health and Primary Care Services, 3.a.ii. Behavioral Health Community Crisis Stabilization Services, 4.a.iii. Strengthen Mental Health and Substance Abuse Infrastructure Across Systems. The common component across these projects is the need to co-locate behavioral health services with medical and/or substance abuse settings. A waiver would address a) the ability of a chemical dependency service provider to travel to different primary care locations and mental health clinics to complete substance use screenings, assessments and treatment sessions (currently prohibited without satellite site approval), c) alleviate the

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#	Regulatory Relief(RR)	RR Response
		burden of counting and reporting which is a barrier even though the OMH regulations may allow for providing a small percentage of mental health services in a primary care setting, D) the challenge of meeting DSRIP goals to reduce ED and inpatient admissions for a patient population by addressing their mental health and substance abuse needs in healthcare integrated settings in order to maximize recovery and functioning E) the expansion of services through triage services in currently licensed facilities to reduce patient safety risks. PPS policies and procedures will define mental health and substance abuse clinical roles, qualifications, orientation, practice and documentation standards and clinical supervision and quality evaluation and monitoring for all mental health and substance abuse clinicians embedded in DSRIP projects including an organization leadership and quality oversight structure for mental health and substance abuse clinicians embedded in DSRIP project sites. Policies and procedures will be consistent with The Joint Commission standards regarding human resources, competency assessment, credentialing, privileging etc. PPS would continue audit activities for unforeseen safety concerns.
6	10 NYCRR Part 670 - Determination of Public Need for Medical Facility Establishment	This regulatory waiver will primarily impact projects 3.a.i. Integration of Behavioral Health and Primary Care Services. 4.b.ii. Increase Access to Disease Prevention Care and Management in Clinical and Community Settings. An expedited Certificate of Need process, or some form of relief from the CON requirement would facilitate the rapid establishment of co-located services to reduce the risk of a delayed start and inability to meet the timeline established to meet metrics and milestones. All services would be delivered by licensed professionals and governed by policies and procedures already approved by the Department of Health for sponsoring clinics. There is no impact to patient safety due to this factor but regular audit protocol will be maintained for unforeseen events.
7	10 NYCRR Part 86 (4.9) Relief Threshold	It is precisely these regulations today that do not permit the provision of integrated care or the billing for care as the visit threshold is exceeded. This regulatory waiver will primarily impact projects 2.a.i. Create an Integrated Delivery System focused on Evidence-Based Medicine and Population Health Management, 3.a.i. Integration of Behavioral Health and Primary Care Services, 4.b.ii. Increase Access to Disease Prevention Care and Management in Clinical and Community Settings. The component common across these projects is the need to integrate and provide multiple same day services. A waiver would relieve the threshold requirement currently in place, which limits service reimbursement when multiple services are administered at the same physical location. Alternatively, the current billing structure limits the number of co-located services that are being developed. There is no impact to patient safety with this waiver as this relief would not alter service type or provider licensing and is limited to billing issues.
8	10 NYCRR part 760 Certified Home Health Agency Establishment. N.Y. PBH. LAW § 3605	To create a sufficient network of culturally competent providers across the PPS service area, this waiver will primarily impact projects 2.a.i. IDS, 2.b.iii. ED care triage for at-risk populations, 2.b.iv. Care transitions to reduce 30-day readmissions, 2.b.vi for transitional supportive housing services and 4.b.ii – Increase Access to Disease Prevention Care and Management in Clinical and Community Settings. This waiver would address: a) the limit in choice of providers in rural areas,

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#	Regulatory Relief(RR)	RR Response
		b) the length of time and complexity of obtaining a Certificate of Need (CON) to expand the geography of Home Health agencies, c) the goal of meeting the patient in their community by redefining "site of care" to include patient engagement through the use of culturally competent community based organizations, d) reduce the need for most costly services in regions with limited health care resources to deliver care coordination services including community health workers to address lifestyle changes, medication adherence, health literacy, and self-efficacy in disease self-management, e) an alternative to establishing new Home Health Agencies which would be lengthy and lead to fragmentation of care. There is no impact to patient safety due to the geographic expansion of existing services but regular audit protocol will be maintained for unforeseen events.

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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.

Rochester Regional Health System (RRHS) and University of Rochester Medical Center (URMC) serve as the co-leads of the Finger Lakes PPS. They, along with the providers across the 13-county region, developed an organizational structure supporting adaptable leadership and problem-solving at the local level (delegated model), but within a construct allowing for central services, consistent processes and a singular vision for the FLPPS Integrated Delivery System (IDS) (hub model).
URMC and RRHS are the sole corporate members of the new FLPPS corporation. As such, they have provided initial capital, and the bulk of in-kind staffing and resource contributions during the start-up phase. In addition, they accept foremost accountability for the initial development and financial viability of FLPPS.
The governance authority for FLPPS resides with the Board of Directors (BoD) which guides the work of the Nominating Committee, Governance Committee and Executive Oversight Committee. The Executive Oversight Committee, in turn, is responsible for the PPS Operations Committees (Finance, Information Technology and Clinical Quality), as well as the Naturally Occurring Care Network (NOCN) and Operations Workgroups (Housing, Workforce, Transportation and Cultural Competency). Under this governance model, the BoD is

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the ultimate decision making body and is responsible for FLPPS quality and financial outcomes across the care continuum.
The Executive Steering Committee assesses the PPS progress towards the fundamental goals of reduced re-admits/ED visits, the progress of the projects, and the impact on quality and service. It currently serves as a cross-functional working group reporting to the BoD and coordinating with the C-suite and PMO, which is responsible for facilitating the flow of information across committees and operationalizing approved plans and processes. The Executive Steering Committee is comprised of the co-chairs of the Operations Committees, Operations workgroups and NOCN Workgroups and is chaired by the CEO of FLPPS. This design ensures representation from across the broad FLPPS service area, engagement of specific subject matter expertise and coordination across the Operations Committees and workgroups.
The Governance Committee makes recommendations for changes to the bylaws and providers corporate level policy and procedure review. The Nominating Committee ensures broad representation of partners and subject matter expertise across the PPS governing body.
The Clinical Quality committee is responsible for:
*Establishing clear clinical standards and guidelines
*Ensuring quality outcomes
*Ensuring consistency of clinical protocols and patient flow design across the IDS, encompassing all projects throughout the service area
*Developing core clinical services and processes that will drive care coordination and integration across the PPS.
The Finance Operating Committee is responsible for:
*Developing and managing the funds flow and budget
*Developing and overseeing the performance based contracting process
*Developing the plan for financial sustainability for the PPS including the framework for transforming Medicaid payment from fee-for-service to value-based payments for the FLPPS provider network
The Information Technology (IT) committee is responsible for:
*Establishing data standards across the PPS
*Developing and implementing a strategy for the bidirectional sharing of information across and amongst all FLPPS providers
The Operations Workgroups - transportation, housing, workforce and cultural competency - are responsible for designing the PPS-wide plans for transportation, housing, workforce and cultural competency respectively.
NOCN Workgroups are responsible for local project execution and for ensuring that the right providers and CBOs are engaged in the projects and development of core services.

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: **9_SEC021_Governance and Operation Structure_141219 DSRIP App.pdf**

Description of File

FLPPS Governance and Operation Structure

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File Uploaded On: 12/21/2014 10:41 AM

***Structure 2:**

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

The FLPPS governance structure has been designed to allow for adequate input from across a vast and diverse service area, while ensuring that FLPPS develops into an IDS. The geographic hubs (NOCN Workgroups) push DSRIP project planning and implementation closer to the sites of care and strengthen local engagement, while the core hub (Operations Committees and workgroups) set consistent standards and methodologies for PPS adoption. The BoD will evaluate the efficacy of this structure annually, and modify as necessary to ensure adequate information sharing, and effective decision making and management processes.
Each level of the FLPPS governing body has specific roles and responsibilities according to committee-defined charters, or in the case of the BoD, bylaws. The collective defined responsibilities of the governing body, C-suite and PMO ensure proper flow of information and decision making processes, supporting management of DSRIP implementation. The C-suite and PMO, led by the CEO, are responsible for operationalizing processes.

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The BoD is the ultimate decision-making body and is responsible for approving the PPS business plan, budgets, funds flow and the gradual delegation of accountability to the Executive Oversight Committee, Operations Committees and the NOCN workgroups.

The Executive Steering Committee, chaired by the CEO, synthesizes and communicates information and recommendations from Operations Committees for BoD approval. It currently functions as an operations steering committee, but as the PPS matures authority will be delegated to this committee by the BoD. It is responsible for:
*Monitoring, advising, and ensuring execution of the implementation plan and achievement of milestones
*Setting expectations for committee deliverables to meet DSRIP milestones and deadlines
*Working directly with the C-Suite executives and PMO to vet deliverables and support decision-making around the PPS implementation plan

Operations Committees, individually staffed the FLPPS CMO, CFO, CIO, EVP of Network Development and/or project managers according to subject matter expertise, develop and set standard methodologies:
*Leveraging content expertise on each committee to ensure proper development of services and processes that will drive care coordination and integration across the PPS
*Ensuring consistency and coordination of project design elements across projects, the service area, and the overall IDS

The Operations Workgroups, staffed by the FLPPS project managers, are responsible for developing PPSs-wide plans and designs for their respective areas of focus - workforce, transportation, housing and cultural competency.

NOCN Workgroups, staffed by FLPPS project managers, are responsible for adaptation and execution of projects at the hub level, including:
*Identifying roles for each partner organization within the NOCN for each DSRIP project
*Informing clinical redesign, care coordination and other processes of care, as well as IT infrastructure requirements for DSRIP specific to the NOCN catchment area
*Local monitoring of providers to identify challenges and barriers to implementation, reporting risks for poor clinical outcomes or financial distress to the Executive Steering Committee

In order to ensure ongoing engagement and buy-in from providers across the region, which is critical to adequate governance and management of FLPPS, all meetings of the FLPPS governing body will include call-in and webinar functionality. Over time, enhanced video-conferencing will be implemented to enable remote face-to-face meetings, facilitating efficiencies around communication across a vast geographic region.

As FLPPS matures the governance structure will evolve into one that delegates more authority to the geographic hubs and the Executive Steering Committee, ensuring adequate governance and management across a vast and highly complex service area.

***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.

Structure:
Under the authority of the BoD, the Clinical Quality Committee, staffed by the Chief Medical Officer (CMO), is responsible for all clinical quality outcomes. Specific committee functions include:
1) Developing and monitoring clinical standards based on DSRIP Domain 1 and Attachment J metrics, and developing data-driven dashboards and benchmarking
2) Approving clinical protocols and care management processes, ensuring adherence across the PPS
3) Structuring, guiding and supporting resource-challenged PPS providers to realize successful clinical outcomes; and
4) Incorporating feedback from Medicaid beneficiaries.

The NOCN workgroups are responsible for monitoring clinical outcomes at the local level and for providing feedback to the Clinical Quality Committee regarding providers at risk for poor quality outcomes and in need of technical assistance or other support.

Process:

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*Clinical Committee and CMO will drive collaboration of primary and specialty care physicians in the development of FLPPS-wide "consensus care guidelines" that will be reviewed and approved by the committee, in addition to all clinical standards and performance measures.
*Clinical Quality Committee will collaborate with Finance Committee, the CMO and Chief Financial Officer (CFO) to develop a system of accountability through clear pay for performance contractual expectations informed by Domain 1 and Attachment J metrics, including quality improvement support and consequences for continued poor performance.
*Dashboards reflecting key metrics will continually evolve over the course of the DSRIP period to provide accountability and transparency for benchmarks, provider comparison, and targeted areas for improvement.
*Dashboards will be reviewed at the NOCN workgroups, Clinical Quality Committee, Executive Steering Committee and the BoD meetings for effective oversight and a focus on rapid root cause analysis and feedback loops in situations requiring monitoring of clinical performance.

***Structure 4:**
Where applicable, outline how the organizational structure will evolve throughout the years of the DSRIP program period to enable the PPS to become a highly-performing organization.

The FLPPS governance body will mature over time as the PPS leadership and providers gain an enhanced understanding of the delivery system integration necessary for the transformation of clinical care and payment. It is expected that an early evolution, during the first demonstration year, will include a transition from the interim Board of Directors and committee members to a more formally nominated and elected slate of directors and committee members. In parallel, the PPS will hire full-time executive leadership and more authority will be delegated to the Executive Steering Committee and the NOCN workgroups. Over time, FLPPS will evolve from a collaborative group of providers working on projects into a truly integrated delivery network with core systems and processes that support members and providers in achieving the triple aim and financial sustainability. This transformation will be driven by the performance improvement infrastructure and dashboards, as well as the funds flow model developed by the FLPPS Finance Committee, which rewards business models with high returns on performance investments. As providers actively engage in the process of negotiating performance contracts, they will naturally gain an operational understanding as to how they will transform themselves and their role within FLPPS based on their contractual obligations and the funds flow methodology. As the PPS is successful in modifying Medicaid health plan contractual relationships away from traditional fee-for-service and toward pay-for-performance and risk-based contracts, FLPPS expects that there may be a need to adapt the governance and potentially even the overall corporate structure to meet new operational requirements.

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.

All levels of our governing body are currently populated by interim members; it is expected that a formal nominations and elections process will be undertaken during DY1.

Board of Directors: 19 voting members and 2 non-voting members as follows: (i) 5 exoficio representatives from each of the 2 corporate members; (ii) 1 representative nominated by each of the five FLPPS NOCNs (regional hubs); (iii) 1 representative from an FQHC, county public health and county mental health, and (iv) 1 Medicaid beneficiary who is served by the PPS and who does not have a conflict of interest (or an immediate family member with a conflict of interest) whether financial or otherwise with the PPS. The CEO or Executive Director of FLPPS and a representative of the Finger Lakes Health Systems Agency (FLHSA) sit on the Board as exoficio non-voting members. Officers include a chair, vice chair, secretary, treasurer and vice-treasurer.

The Clinical Quality, Finance and IT Operations Committees each have approximately 15-20 members with a blend of functional expertise and representing a cross-section of provider types and the broad geographic service area.

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

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All levels of the PPS governing body are currently populated by interim members. It is expected that an early evolution, during the DY1, will include a transition from the interim Board of Directors and Committee members to a more formally nominated and elected slate of directors and committee members.
Board of Directors: Directors were appointed via a nomination process in which the two corporate members (RRHS and UR) each nominated 5 Directors. The Organizing Committee (just prior to transition to the Executive Steering Committee) and other PPS member representatives conducted extensive conversations with PPS partners and stakeholder organizations to generate the nominees for the remaining 9 positions. The final slate of nominees was posted for public comment. Exoficio Directors on the BoD from URMC include the CEO of the Clinical Enterprise; COO and CFO of the largest URMC safety net hospital, Strong Memorial; and two physician executives. Exoficio members from RRHS include the COO; two physician executives; the CFO; and the chief strategy officer. The 9 other directors include a rural health network executive; a health system physician CEO; a dentist and 2 lay executives from FQHCs; the executive director of a substance abuse agency; a county public health director; a county mental health director; and a Medicaid member.
The Executive Steering Committee was filled using appointments of the co-chairs of the Operations Committees and Workgroups by the co-leads, and nomination by each NOCN of a representative to sit on the Committee.
The nomination process for the operations committees and workgroups was completed via numerous e-mail surveys, requests for nominations via webinar and e-mails, and outreach by members of the predecessor body to the Executive Steering Committee, the Organizing Committee as well as other FLPPS leadership and engaged stakeholders at the PPS and NOCN levels.
Clinical/Quality: Experienced safety net clinicians and known leaders of delivery system transformation were identified within each of the co-lead organizations to co-chair the committee. The co-chairs reviewed the nominations and identified members who represented the continuum of health services across the geographical makeup of FLPPS, including (but not limited to) clinical representatives from hospitals (IAAF and non-IAAF), health systems, health plans, academic medical centers, medical societies, health homes, federally qualified health centers, behavioral health & substance abuse providers, MCOs and departments of public health and mental health.
Finance: The CFOs from each of the co-lead organizations were invited to co-chair committee. The CFOs reviewed the list of nominations and identified members who would represent the unique financial makeup of FLPPS. Represented organizations include small, community based organizations with singular revenue streams and small operating budgets, large, complex hospital systems with various revenue streams and sizeable operating budgets, financially fragile organizations and financially stable organizations. Members include, but are not limited to financial and administrative experts from a similar wide range of providers to the Clinical/Quality Committee.
IT: The Chief Information Officer from RRHS and an IT Executive from URMC were invited to co-chair the committee. The co-chairs reviewed the list of nominations and selected members who represented organizations with various IT capabilities. Members include, but are not limited to IT and clinical experts from a similar wide range of providers to the Clinical/Quality and finance Committees, as well as the local RHIO.
The Cultural Competency, Workforce, Transportation and Housing workgroups, in addition to the NOCN workgroups, were populated by a similar methodology as above, each led by a highly respected regional leader & subject matter expert

***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.

1/3 of the Medicaid members in the PPS are served by URMC and its affiliates, 1/3 by RRHS and its affiliates and 1/3 by providers not affiliated with either URMC or RRHS. As such, providers and community-based organizations not directly affiliated with URMC nor RRHS represent at least ⅓ of the governing body.

BoD members: 5 URMC reps, 5 RRHS reps, 1 rural health network executive, 1 health system physician representative, 3 FQHC representatives (1 dentist, 2 lay executives), 1 substance abuse rep, 1 county public health director, 1 county mental health director, and 1 Medicaid member.

Executive Steering Committee: Co-chairs of each of the Operating Committees and workgroups and a representative from each of the NOCNs to ensure not only broad provider and area of expertise, but also geographic representation.

Operations Committees: Populated via specific committee competency requirements per committee role, ensuring geographic and provider/community organization type representation.

***Process 4:**

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

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based organizations.

PPS coalition partners have roles throughout the organizational structure and a myriad of opportunities to engage in the work of FLPPS. They are included and represented at every level of organizational structure, from the Board of Directors to the Operations Committees and the Operations and NOCN workgroups.

There is 5% set-aside in the funds flow to fund contracts with non-safety net CBOs as the PPS engages them for their critical services provided as components of the new IDS. Initially, it is likely that the CBO services will be funded via a combination of current funding sources, grants and PPS contracts, as well as expansion as appropriate of any existing MCO contracts. Over time the goal will be to completely integrate the CBOs into a PCMH-based system of care in which they play a vital role in achieving and improving health for Medicaid and uninsured members and they are therefore contracted by MCOs based on actuarial estimates as to their impact on total cost and quality.

***Process 5:**

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

Issues requiring approval of the two corporate members, URMC and RRHS include, but are not limited to:
*To approve and interpret the statement of mission and philosophy adopted by the corporation;
*To approve and interpret the strategic plan of the Corporation;
*To amend or repeal the Certificate of Incorporation and Bylaws of the Corporation and to adopt any new or restated Certificate of Incorporation or Bylaws of the Corporation;
*To approve the annual budget of the Corporation;

Issues requiring super-majority vote include, but are not limited to:
*Performing Provider System ("PPS") Partner network;
*Project selection by the overall PPS and each PPS Partner;
*All PPS responses to state required applications, project plans and related submissions;
*Funds flow model as recommended by the PPS Finance Committee;
*Modification of the Funds Flow – only upon formal recommendation from the Finance Operating Committee of the PPS and as allowed by State and CMS guidelines;
*Payments to PPS Partners as per the funds flow model – such payments can only be approved such that they do not exceed the total amount of payment from the state to the PPS for each performance/payment cycle;
*Disputes between PPS Partners and the PPS related to payments as per the fund flow model adopted by the PPS;
*Sanctioning and/or removal of a PPS Partner due to performance issues, suspected fraud, and/or other behaviors not consistent with the principals of the PPS;
*Prioritization of capital requests;
*Recommendations for closures and/or repurposing of institutions and/or other organizations;
*Recommendations for PPS level workforce repurposing, training and placement programs

All other issues will be settled by a simple majority vote of the Board of Directors.

***Process 6:**

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

Disagreements at the Board of Directors level will be resolved via the process outlined in the FLPPS bylaws, including specific guidelines as to what issues can be decided via a simple majority vote, a supermajority vote, or are reserved powers for the two sole corporate members. The corporate members have a long history of working together in an overlapping service area and have developed strong relationships across their respective corporate counsel that enable rapid problem-solving when conflicts arise. Provider and/or member conflicts and /or issues will be resolved via the FLPPS staff in coordination with the operations committees and Board of Directors; there will be a formal grievance process for both providers and members.

***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.

All of the FLPPS governing bodies, from the Board of Directors to the various Operations Committees and NOCN Workgroups, are populated with diverse and representative groups of providers, stakeholders and Medicaid members, thus ensuring that the process for decision making does not become opaque and/or overly hospital centric. The minutes of the meetings of all committees and Board meetings, with the exception of executive sessions, will be publically available via the FLPPS website. In addition, chairs from each of the committees and workgroups will provide in-person reports at semi-annual Project Advisory Committee (PAC) meetings. Weekly webinars will continue to be critical venues through which the FLPPS team shares important decisions and potential barriers with its stakeholders.

***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.

Stakeholder engagement has always been and will continue to be a top priority to FLPPS. FLPPS is committed to having a transparent process and has regularly communicated information regarding planning and application drafting to its stakeholders.

Stakeholders can access information on the FLPPS website and receive weekly newsletters. Understanding the importance of 2-way communication, FLPPS has an information e-mail where providers can submit questions and receive responses within less than 48 hours. For more urgent questions, providers may call our hotline. In addition, all webinars are opened up for questions at the conclusion of the presentation.

Early in the planning process, FLPPS understood that Medicaid member representation is a critical success factor in ensuring that member needs are met. Medicaid members have a representative who is a voting member of the Board of Directors and there will also be a Medicaid representative on each NOCN workgroup.

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.

Following a number of in-person workgroups and informational interviews held by the co-lead organizations, the FLPPS team sent a digital communication in July 2014 to all providers who had expressed interest in participating in the FLPPS Project Advisory Committee (PAC). The email explained the state's methodology for electing PAC members and announced the first PAC meeting.

The first official PAC meeting was a face-to-face held, in mid-August. This meeting was attended by over 100 partner representatives from across the PPS, identified based on the state's recommended selection process. The purpose of the meeting was to orient PAC members to FLPPS and share the progress that had been made to date, the work that was being done at the co-lead organizations, and answer questions regarding provider roles and responsibilities.

Following the first in-person meeting, the FLPPS team hosted monthly, and at times weekly, webinars to solicit feedback from PAC members on the DSRIP Project Plan Application drafting process. Webinars were generally attended by 100-150 PAC members. The FLPPS team shared information about the outcomes of the Community Needs Assessment, provided technical assistance on Request for Qualifications and assessments that had been disseminated, shared updates from the state and provided attendees with real-time responses to their questions regarding their roles in FLPPS.

In addition to the webinars, the FLPPS team hosted its first round of NOCN meetings between October and November. PAC members were invited to attend in-person to meet project managers and help inform the project implementation planning process. These NOCN meetings allowed PAC members an opportunity to participate in events that were geographically convenient.

Moving forward, in-person PAC meetings will be held no less than biannually, with bimonthly- to- weekly webinars in the interim.

***Committee 2:**

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

Throughout PPS development, the PAC has functioned as the core of the PPS, having operational and strategic impact via nominations of PAC members to the executive body - the Executive Steering Committee, as well as the Operations Committees, the Operations Workgroups and the NOCN Workgroups. PAC members participating in Operations Committees have played a key role in developing the strategic content necessary to populate the DSRIP Organizational Application.

The PPS will continue to solicit feedback from the PAC. Additionally, the PPS will work with the PAC to refine its communication strategies to ensure the transparent and adequate flow of information throughout the region. The PAC will meet in its entirety for PPS-wide summits no less than quarterly. Meetings will be in-person in DY year 1 and that they may be held either in-person or via webinar beginning in DY 2.

***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).

PAC has evolved into a key player of the FLPPS governance structure. PAC members populate both the NOCN Workgroups and the Operations Committee.

FLPPS partnered with the Finger Lakes Health Systems Agency (FLHSA), a regional health planning group with extensive experience in data analysis related to population, health care utilization, and health system capacity to undertake the CNA. Under the direction of FLPPS, the FLHSA undertook an over six-month process to engage providers, PAC members, and other stakeholders from across the FLPPS service area in conducting a comprehensive CNA. Quantitative and qualitative methods (including extensive community and stakeholder input through CNA information sessions) were implemented throughout the course of CNA completion. Various drafts of the CNA were posted to the FLPPS website and emailed to the PAC for review. PAC and stakeholder comments were submitted to FLHSA for consideration.

***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.

Committees were populated by nominations received from interested providers from across the FLPPS service area. Co-chairs and initial committee members, along with project managers who orchestrated a number of NOCN-level planning days, reviewed nominations and posed additional suggestions for membership to ensure that at membership represented at least one member from each of the five NOCNs and at least one member from each of the relevant provider types.

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 Finance Committee and the Board of Directors, serving as the Audit Committee, will jointly vet and recommend a full-time or part-time qualified executive to serve as the Compliance Officer, who will have a joint reporting relationship to the CEO and the Board of Directors. The Compliance Officer will attend all meetings of the Board of Directors and Finance Committee. The FLPPS Compliance Officer will periodically report on compliance activities to the FLPPS Board of Directors acting in its role as audit committee.

***Compliance 2:**

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

*A standing Compliance Committee, will be formed and chaired by the Compliance Officer, who will report to the Board of Directors and CEO.

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*The Compliance Committee and the Compliance Officer will jointly agree upon the DSRIP, state and federal rules and regulations that will be included in this oversight role, and will comply with the published Medicaid oversight regulations.
*Written policies and procedures will describe compliance expectations of all FLPPS staff, providers and partners and their respective staffs.
*Expectations include annual training to employees and Board of Directors on how to deal with and report potential compliance issues and the process by which compliance problems are investigated, reported and resolved.
*An anonymous Compliance Integrity Hot Line will be implemented. The Compliance Officer will be responsible for reviewing the Hot Line and reporting the contents and actions taken to the Executive Team (CEO, CFO, COO) on a monthly basis.
*All material agreements, contracts, policies and procedures require review by the Compliance Committee prior to execution.
*The Compliance Officer will annually attest to NYS OMIG
*Monthly exclusion screening will occur

***Compliance 3:**

Describe the compliance training for all PPS members and coalition partners. Please distinguish those training programs that are under development versus existing programs.

*The Compliance Officer will be hired by the Board of Directors, in its role as audit committee, with input from the finance committee and will not have any ties to any of the FLPPS providers.
*The Compliance Officer will be responsible for developing compliance education and training programs, including a FLPPS-wide HIPAA program, along with establishing audit procedures. Disciplinary policies that encourage good faith participation will also be developed. In addition, included will be a policy of non-intimidation and non-retaliation for all affected persons.
*Annual training and education will be provided to all existing and new FLPPS employees, Directors and all affected persons associated with FLPPS through a variety of communicative options.
*A FLPPS Compliance Website will be developed with an easily accessible link for partners and members to submit complaints.
*The Compliance Officer will review code of conduct and compliance policies and programs of all FLPPS partners and how they relate to DSRIP. Any deficiencies will be addressed through the FLPPS compliance program.
*A schedule will be developed to audit and monitor the compliance programs of all FLPPS partners.

***Compliance 4:**

Please describe how community members, Medicaid beneficiaries and uninsured community members attributed to the PPS will know how to file a compliance complaint and what is appropriate for such a process.

*Compliance and other complaints will be able to be filed through a FLPPS Compliance Integrity Hot Line.
*All hotline complaints will be received and reviewed by the Compliance Officer.
*Information about the FLPPS expectations for standards of care and customer service, what types of complaints would be appropriate to file, as well as the hotline number, will be communicated through a variety of communications vehicles, including member mailings and e-mail blasts, posted in offices, as well as dissemination via FLPPS providers, CBO partners, other stakeholders engaged with FLPPS and local government programs that interface with Medicaid members.
*FLPPS will also work with the various Medicaid Managed Care plans to help make their members aware of the Hotline.

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.

The FLPPS Finance Committee has been in place since October 2014. The specific tasks for the Finance Committee include:
*Develop and approve policies and procedures for funds flow.
*Implement mechanisms for financial accountability and oversight including internal control and cash management policies.
*Bring material exceptions/questions/issues and variances to budget to the attention of the FLPPS Board of Directors.
*Introduce action plans for any variances over established benchmarks.
*Monitor financial performance of FLPPS and all Partners and report to the Board of Directors monthly.

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*Review and approve annual FLPPS operating and capital budgets.
*Work with the Clinical Committee, Executive Steering Committee and area Health Plans to develop recommendations for a transition from the current mainly fee for service provider contracts to specific pay-for-performance initiatives.

The funds flow developed by the Finance Committee, which has been shared with the PPS via webinar and will be the topic of ongoing communications at the PPS and NOCN level, is designed to ensure provider and CBO engagement in successful implementation of DSRIP projects and the transformation into an IDS.

***Organization 2:**

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

The financial structure for FLPPS has three components:
(1) The FLPPS corporate Board of Directors
(2) The Finance Committee
(3) The FLPPS CFO and finance staff
The Finance Committee and the FLPPS CFO have principle accountability for and oversight of all financial matters for FLPPS.
The Finance Committee will work with the CFO and the Board of Directors to finalize the financial policies and procedures to be used by FLPPS, including but not limited to:
*Spending authority limits
*Completing the design and implementation of DSRIP fund distribution
*Developing the annual budget process
*Defining the financial metrics that Partner organizations are expected to meet
*Developing the financial compliance program in conjunction with the Compliance Officer and the Board of Directors
*Identify Medicaid & Medicare sanctioned providers and evaluate their further participation in FLPPS
As the fiduciary to DOH, FLPPS will be receiving and distributing DSRIP funds beginning on April 1, 2015.

***Organization 3:**

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

The Board of Directors will serve as the Audit Committee, and as such, will coordinate with the Finance Committee, CFO, CEO and Compliance Officer to determine if a single audit firm can meet the needs of both financial and general compliance. Irrespective of this decision, the Board of Directors will issue an RFP and select a qualified external auditor for a contract that will be reviewed annually for renewal or re-bid. The auditor contract will be re-bid at a minimum every 3 years. Should a separate contract be required for a general compliance auditor, the RFP and selection for this will be undertaken by the Finance Committee in coordination with the Board, as the audit, CFO and Compliance Officer. When complete, the FLPPS compliance program will meet all requirements of New York State Social Services Law 363-d.

***Organization 4:**

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

The Compliance Officer will design and establish a compliance program for FLPPS in accordance with New York State Social Services Law 363-d. The first draft of the plan will be reviewed for input by the Finance Committee and a second draft will be reviewed by the Board of Directors prior to approval and adoption by the Board in its role as the audit committee. The compliance program will be reviewed at a minimum annually by the compliance officer, finance committee and the Board of Directors in its role as audit committee, in addition to any interim reviews and updates triggered by any changes in the New York Social Services Law 363-d.

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.

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Performance data, collected and reported via dashboards developed based on a "balanced scorecard" framework, will be monitored through a series of "tollgates," starting with review by the FLPPS PMO, Director of Performance Improvement and CMO; then by the Clinical Quality and Finance Committees; followed by the Executive Steering Committee and finally reviewed and discussed quarterly at the meetings of the FLPPS Board of Directors. As described earlier in the Governance sub-section, FLPPS will use clear contractual expectations, standardized consensus based performance metrics, improvement support, and consequences for continued poor performance as the processes by which the PPS will monitor performance. Dashboard metrics will continually evolve over the course of the PPS period to incorporate benchmarks, provider comparison and targeted areas for improvement.

***Oversight 2:**

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

FLPPS will have a proactive process involving engagement with PPS partners from planning and into the execution stages by FLPPS project managers, other staff, project team SMEs and members of the Operations Committees. An Office of Advanced Performance Improvement will be led by an expert in performance excellence and will have staff resources available to partner with providers for both the initial design of projects and improvement efforts when performance issues arise. Lower performing members will receive feedback as to their performance deficits and technical assistance, as resources allow, to assist and support the provider in gaining performance improvement.

***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.

As discussed earlier, FLPPS will use clear contractual expectations, standardized consensus based performance metrics and improvement support to monitor and attempt to improve performance when necessary. Performance data will be transparently shared and discussed on a regular basis such that a poorly performing provider will have early indications and interventions when performance has begun to suffer, or appears at risk. These providers will be placed on a Corrective Action Plan (CAP). Providers on a CAP who are either unable to engage in performance improvement activities to change performance and/or are unwilling to do so will undergo a process of peer review overseen by the Clinical Committee in coordination with the FLPPS assigned staff and the Compliance Officer. After a prescribed amount of time and set of attempted interventions as per the policies and procedures of FLPPS, which will be compliant with the standard terms and conditions of the Waiver, the Board of Directors may be recommended by the Clinical Quality Committee and Compliance officer to remove the poorly performing member.

***Oversight 4:**

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

The PPS will incorporate into its policies and procedures Medicaid beneficiaries' existing complaint and appeal processes that will reflect concerns regarding dissatisfaction, appointment scheduling, denied referrals. Additional policies, procedures and processes will be developed by the Clinical Committee as needed, with feedback from the cultural competency workgroup to ensure that adequate outreach is undertaken to gain engagement with Medicaid beneficiaries across the spectrum of the PPS diversity. The FLPPS will solicit feedback from Medicaid beneficiaries as to their care experience with the provider.

***Oversight 5:**

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

FLPPS will develop policies and procedures for the process that will be undertaken to remove providers from the PPS due to quality, fraud or other issues. This will include the development of a Corrective Active Process. (CAP) As part of the CAP process, Medicaid beneficiaries and their advocates will receive advance notice of a potential action to remove a provider from the PPS that the Medicaid beneficiary has received care from within a prescribed period of time. The Medicaid beneficiaries and their advocates will be provided with information on how this may impact the member. Additional options for seeking ongoing care will be made available, particularly if there is a risk that ongoing care may not be available with the removed provider.

Section 2.7 - Domain 1 – Governance Milestones:

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Description:

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

- Implementation plan outlining the PPS' commitment to achieving its proposed 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.

Finger Lakes PPS worked collaboratively with Finger Lakes Health Systems Agency (FLHSA) to conduct an analysis of community need across the 13-county PPS region. Throughout this process, in-depth quantitative analyses and extensive qualitative feedback were intertwined – each guiding the other through a cyclical progression of data aggregation, presentation, and solicitation of feedback.

CNA development began in spring 2014 via structured outreach to a broad network of community stakeholders to discuss the DSRIP opportunity, ascertain level of interest, initiate an assessment of perceived community needs, and explore PPS/provider/organization potential roles in addressing those needs.

Subsequently, the (then four) emerging PPSs shared the preliminary analysis of regional health status with over 250 service providers, community partners, and interested community members, leading to the identification of perceived gaps in service and a prioritization of community need. This feedback was the foundation driving subsequent analyses activities.

Additional quantitative analyses, conducted through summer 2014, offered a more thorough understanding of the cause and effect of health system utilization by the Medicaid/uninsured population. Methods included the combining of multiple datasets, geographic variation analyses, bivariate analyses, and multivariate modeling techniques.

Input on the results of these additional quantitative analyses was sought from an even broader cross-section of the community, via presentations at Project Advisory Committee (PAC) and Naturally Occurring Care Network (NOCN) meetings.

Simultaneously, qualitative data was collected through focus groups, surveys, key informant interviews and meetings with PPS partners.

Finally, to further test conclusions, several versions of the CNA, along with the proposed project set, were distributed across the FLPPS network and posted on the FLPPS website for public comment.

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

Quantitative information and data resources leveraged in the initial, preliminary analyses included state-provided data and additional data sources for more in-depth exploration and subgroup analyses, including: 2010 US Census data (US Census Bureau); Vital Statistics of New York State (NYS) (NYS DOH); Salient non-PHI Medicaid Claims Database; Statewide Planning and Research Cooperative System Inpatient and Outpatient Hospital Claims Database (NYS DOH); Center for Healthcare Workforce Studies HPSA Data; Managed Care

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Provider Network Data; NYS Prevention Agenda Dashboard; NYS PQI Data; NYS CHIRS; Behavioral Risk Factor Surveillance System; and the DSRIP Clinical Metrics Dataset.

Further analyses utilized: Western Region Behavioral Health Organization's quarterly progress reports; 2012 American Community Survey (US Census Bureau); Hospital and nursing home cost reports; Directories of community-based service providers obtained from three regional 2-1-1 centers; FLHSA Health Disparity Reports; FLHSA Regional Chart Books; FLHSA Regional Profiles; Sage Commission Report; New York State Health Foundation Resources; CCSI BH Resource Database; Catholic Family Center records; and Community Health Care Association of New York State reports.
In addition, qualitative information was gathered through:
*5 meetings with provider workgroups to establish needs/priorities in geographic sub-areas
*1 community survey for additional input on projects
*3 community engagement meetings to gain consensus on initial project selection
*2 PAC meetings to solicit feedback from partner organizations and interested community members
*6 NOCN planning meetings to determine regional needs and geographical disparities
*1 regional Commission on Community Health Improvement meeting to broadly disseminate preliminary CNA results
*1 public webinar
*15 focus groups targeting specific at-risk populations
*30 key informant interviews around complex issues facing these at-risk populations

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	20	18
2	Ambulatory surgical centers	32	6
3	Urgent care centers	46	13
4	Health Homes	7	7
5	Federally qualified health centers	58	56
6	Primary care providers including private, clinics, hospital based including residency programs	1664	1111
7	Specialty medical providers including private, clinics, hospital based including residency programs	2459	1535
8	Dental providers including public and private	888	49
9	Rehabilitative services including physical therapy, occupational therapy, and speech therapy, inpatient and community based	3588	33
10	Behavioral health resources (including future 1915i providers)	3699	94
11	Specialty medical programs such as eating disorders program, autism spectrum early	2	2
12	diagnosis/early intervention	5	5
13	Skilled nursing homes, assisted living facilities	135	62
14	Home care services	26	23
15	Laboratory and radiology services including home care and community access	20	18
16	Specialty developmental disability services	143	31

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#	Provider Type	Number of Providers (Community)	Number of Providers (PPS Network)
17	Specialty services providers such as vision care and DME	100	5
18	Pharmacies	25	10
19	Local Health Departments	13	12
20	Managed care organizations	7	2
21	Foster Children Agencies	13	12
22	Area Health Education Centers (AHECs)	1	0

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

***Infrastructure 2:**

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

While the FLPPS region as a whole has a large number of healthcare resources covering the full spectrum of acute, primary, long term, specialty and behavioral health care, the system remains unbalanced. Roughly one-third of the region's population lives in a Primary Care Health Professional Shortage Area (HPSA). Further, the incidence of Prevention Quality Indicator (PQI) hospital and emergency room admissions is a strong indicator of the under-use of primary care, leading to poor health outcomes, siloed delivery of care and inappropriate utilization of services:

*The PQIs which are attributable to chronic disease (diabetes, respiratory, and heart) account for 85% of all potentially preventable inpatient hospitalizations in 2012.
*Diseases of the circulatory, respiratory, digestive and endocrine systems account for 13,856 (almost 20%) of Medicaid hospital admissions.
*Those with behavioral health diagnosis are high users of health care services. Over 50% of active behavioral health super-utilizers were seen in the ED for general signs and symptoms at some point during 2013, while 44% were seen for injuries.
*Over 50% of all treat and release visits for chronic conditions are attributable to behavioral health diagnosis.
*The infant mortality rate in the FLPPS region has remained relatively stagnant over the last two decades, moving from 7.3 deaths per 1,000 births in 1994 to 6.4 deaths per thousand in 2011.

To address these disparities, the PPS must create a regional Integrated Delivery System (IDS) that: (1) Increases access to primary care, including an increase of both locations of and capacity at FQHCs, expanded hours of operation at PCP practices and open-access scheduling to support transitions of care; (2) Integrates behavioral health and primary care services at a single location, across all NOCNs, to improve the management and identification of patients with co-morbidities; (3) Repurposes acute services in select rural NOCNs by creating ambulatory campuses with co-located services that includes a robust offering of care modalities to meet community needs. Interventions might include the consolidation of services and enhancement of primary care access. Emphasis should be placed on communities with financially distressed hospitals so that appropriate ambulatory services remain as inpatient services are consolidated into adjacent communities; (4) Replaces a certain number of skilled nursing beds with Medicaid Assisted Living beds, providing safe housing, primary care, and supportive care management services to patients in an environment that has a lower per-diem cost; (5) Develops a proactive coordinated care model that expands Health Home care management and establishes the PPS a point of contact for individuals to be connected with services; (6) Utilizes telemedicine to expand resource capacity across systems; (7) Considers medical-village type delivery systems, such as acute-to-ambulatory or SNF-to-alternatives services; and (8) Develops ambulatory ICUs in high need areas.

Section 3.3 - Community Resources Supporting PPS Approach:

Description:

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

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***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	358	14
2	Food banks, community gardens, farmer's markets	541	0
3	Clothing, furniture banks	541	0
4	Specialty educational programs for special needs children (children with intellectual or developmental disabilities or behavioral challenges)	143	31
5	Community outreach agencies	500	50
6	Transportation services	159	25
7	Religious service organizations	832	10
8	Not for profit health and welfare agencies	754	50
9	Specialty community-based and clinical services for individuals with intellectual or developmental disabilities	143	17
10	Peer and Family Mental Health Advocacy Organizations	174	20
11	Self-advocacy and family support organizations and programs for individuals with disabilities	1204	20
12	Youth development programs	50	0
13	Libraries with open access computers	146	100
14	Community service organizations	2102	50
15	Education	76	5
16	Local public health programs	77	70
17	Local governmental social service programs	162	150
18	Community based health education programs including for health professions/students	585	50
19	Family Support and training	26	5
20	NAMI	4	1
21	Individual Employment Support Services	195	0
22	Peer Supports (Recovery Coaches)	2	2
23	Alternatives to Incarceration	162	0
24	Ryan White Programs	3	2
25	HIV Prevention/Outreach and Social Service Programs	3	3

***Resources 2:**

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

A plethora of community-based organizations (CBOs) are actively engaged with the PPS target population, providing a range social supports directed at specific demographics, communities or neighborhoods. These CBOs represent a tremendous untapped resource for the PPS, as they are contact points where the PPS target population gathers, and where a level of trust and engagement has already been established. That said, the availability of these organizations has remained somewhat shrouded from the health care community. The estimated number of the CBOs in the service area remains conservative, despite early efforts by the PPS to engage community-based providers in planning activities. The PPS recognizes that over the next year, continuous efforts must be made to outreach and collaborate with CBOs in every NOCN.

Based on identified service gaps, further community resources will need to be developed in the areas of transportation, supportive housing, programs teaching the self-management of chronic disease, patient activation, community based education program for health professionals, nutrition and weight management, as well as a wide range of mental, emotional and behavioral health prevention and

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promotion services for both adult and children, to be determined upon further analysis of the target population and associated needs.

In order to ensure long term sustainability, CBOs must develop a means to monitor program outcomes. Over time, this type of evaluation will allow the PPS to identify best practices and determine programmatic value in preparation for the inclusion of high quality services in a value-based payment paradigm.

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:

In line with the U.S. trends, the population in the region is aging as the "baby boom" generation born in 1946 – 1964 moves toward retirement age. That may substantially affect health and delivery patterns. Over the last 20 years, the region's population has increased only 1.3%; however, the number of persons over the age of 65 has increased by 40,000 and now accounts for 15.4% of the total population. Seventeen-percent of the population is school-aged children. There is near-parity in the number of males and females among younger individuals. However, there is a particular deficit of young adult males in the African American community, especially in the city of Rochester. This trend is thought to be due to disproportionate homicides and incarceration. This deficit increases the number of single-parent households, and decreases male role models.

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

The FLPPS population appears to be racially and ethnically diverse, however the majority of the diversity is located in Monroe County, where the population identifies as 62% white, 22% African American and 6% Hispanic, while the remaining 11 counties identify as 92% white, 4% African American and 3% Hispanic. Consistent with the racial and ethnic composition of FLPPS county populations, the largest rate of non-English speakers is found in Monroe County (about 13% of the population aged 5 and older), with the most reported non-English language spoken at home being Spanish. There is a large refugee resettlement population that speaks more than 32 languages. At an aggregate level, the population of non-English speakers in the FLPPS is much lower than the NYS average. While obtaining direct data on local levels of health literacy is difficult, national research has demonstrated that low health literacy is more prevalent among minorities and those who are socially disadvantaged.

***Demographics 3:**
Income levels:

Having an inadequate income affects many aspects of health: access to care, ability to buy and eat a healthy diet, and adequacy of housing. In fact, 7% of all PPS residents have failed to seek care due to cost. In 2012 the median income of the region ranged from $42,000 in Allegany County to $54,000 in Livingston County, with all counties demonstrating per-capita income below the New York state median income of $58,000. The region is gradually getting poorer in terms of per capita net earnings, compared with national averages. As the population ages and fewer people are employed, wages become a smaller portion of income and transfer payments (pensions, social security, government funds) become a larger portion. To the extent that transfer payments are fixed or at most indexed to the cost of living they will not increase the wealth of the community or individuals.

***Demographics 4:**
Poverty levels:

About 30% of the FLPPS population lives under 200% of the Federal Poverty Level (FPL). Almost two-thirds (65%) of African Americans and 69% of Latinos in Rochester live in households with incomes below 200% FPL. Over three-quarters (76%) of all children ages six and under in Rochester live in or near poverty. Allegany, Cayuga, Chemung, Genesee, Livingston, Monroe, Orleans, Seneca, Steuben, Wayne, Wyoming, and Yates counties all have greater than 10% of their population living below the poverty threshold, with four out of the 13 counties having a poverty rate above the state-wide average. The number and proportion of the population living below the federally defined poverty threshold has increased in the past decade. Poverty rates are highest in the city of Rochester but poor and near-poor live

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in all areas of the region. Racial and ethnic populations in Rochester are especially affected by poverty.

***Demographics 5:**

Disability levels:

Significant portions of the FLPPS are dealing with debilitating levels of morbidity. The percent of the non-institutionalized population that is disabled ranges from 11.4% in Livingston County to 15.5% in Steuben County. All counties in the FLPPS have higher rates of disability than the state-wide average. Of particular note, Rochester and the Finger Lakes region have a significant deaf community, supported by the presence of the National Institute for the Deaf (NTID) and the Rochester School for the Deaf (RSD). In addition, The FLPPS region has over 25,000 OPWDD consumers including almost 4,500 OPWDD consumers in community-based residential care. These consumers are individuals with developmental disabilities, defined as a diverse group of severe chronic conditions that are due to mental and/or physical impairments, and they represent a disproportionate approximately 12% of OPWDD consumers statewide. Access to dental care is a high need for this population.

***Demographics 6:**

Education levels:

Having lower education levels is associated with one's risk for being readmitted to the hospital after discharge. The percent of the population with a high school degree or less ranges from over 52% in Allegany County to about 36% in Monroe County; only two counties (Monroe and Ontario) have a rate that is less than the New York State average. In 2013, the graduation rate in the Rochester City School District, the most urban populous in FLPPS, was 43% according to the NY State Department of Education.

***Demographics 7:**

Employment levels:

The largest sources of employment across the FLPPS include management, business, science and the arts. Regional unemployment rates vary from 5.5 in Yates County to percent to 9.9 in Orleans County. Allegany, Orleans and Steuben counties have rates of unemployment higher than the statewide average. Targeted interventions may be required in these areas, as the trauma associated with long-term unemployment has been found to damage emotional health.

***Demographics 8:**

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

The institutionalized population, as defined by the U.S. Census Bureau, includes those living in prisons, juvenile facilities, nursing homes, psychiatric facilities, hospices, and residential schools for individuals with developmental disabilities. Across the FLPPS region, 2.0 percent of the population is institutionalized in one of these locations. There is a substantial amount of variation by county however; in Orleans, Seneca and Wyoming counties over 5% of the population is institutionalized. Many more Black males than Black females reside in group quarters, a Census designation for institutional (e.g. prison) and non-institutional (e.g. college dormitory) locations not in the general household population People in institutionalized settings often have unique health challenges such as dental needs, diabetes and depression.

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

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

File Name	Upload Date	Description

No records found.

Section 3.5 - Community Population Health & Identified Health Challenges:

Description:

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

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***Challenges 1:**

Leading causes of death and premature death by demographic groups:

The most common causes of death and premature mortality are heart disease and cancer followed at some distance by chronic obstructive pulmonary disease (COPD), stroke, and unintentional injury. Using years of potential life lost (YPLL) to examine deaths before the age of 75, cancer becomes the leading cause of premature mortality, followed by unintentional injury, heart disease, conditions arising in the perinatal period, and suicide. Furthermore, the FLPPS region historically experiences higher rates of infant mortality than either New York state or Upstate New York, and of the top five leading causes of YPLL, suicide appears to be the only cause of YPLL that has been trending upwards from since 2002. African Americans and Latinos consistently experience higher rates of premature mortality relative to whites. The ratio of African Americans experiencing premature death, compared to whites is 2.36, while the Prevention Agenda goal is 1.87. The same hold true for Hispanics compared to whites, with a ratio of2.37 compared to the Prevention Agenda goal of 1.86.

***Challenges 2:**

Leading causes of hospitalization and preventable hospitalizations by demographic groupings:

Diseases of the circulatory, respiratory, digestive and endocrine systems account for nearly 20% of Medicaid hospital admissions and the PQIs attributable to chronic disease (diabetes, respiratory, and heart) account for 85% of all potentially preventable inpatient hospitalizations. Behavioral health disorders represent 17% of all Medicaid hospitalizations with a readmission within 30 days, and 15% of inpatient mental health or substance abuse admissions are for individuals who were homeless at the time of admission. Furthermore, readmissions to acute care beds following a discharge to a SNF account for about 16% of all Medicaid readmissions. African Americans and Hispanics are more likely to experience potentially avoidable hospitalization across all disease types. The ratio of African Americans experiencing preventable hospitalizations, when compared with whites is 2.22, well above the Prevention Agenda goal of 1.85. Again similar disparities exist for the Hispanic population, with a comparative ratio 1.88 whereas the Prevention Agenda goal is 1.35.

***Challenges 3:**

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

The top Ambulatory Care Sensitive Conditions in the FLPPS region are: (1) hypertension: 45,159 beneficiaries (205.4 per 1,000) (2) asthma: 22,251 beneficiaries (101.2 per 1,000); (3) diabetes: 21,462 beneficiaries (97.6 per 1,000); (4) COPD and bronchiectasis: 8,180 beneficiaries (37.2 per 1,000); and (5) CHF: 5,271 beneficiaries (23.9 per 1,000). These illnesses share a number of conditional risk factors including smoking, physical inactivity and unhealthy diet, which are widespread across the population: the FLPPS region falls short of New York State prevention agenda goals for: adult obesity (29.9% vs. 23.%); adult smoking (21.1% vs. 15%); age-adjusted heart attack hospitalizations/10,000 pop. (17.3 vs. 14); and rate of hospitalizations for short-term complications of diabetes/10,000 pop. (7.21 vs. 4.86). Furthermore, being non-white, having low income, being unemployed, having lower education levels, having poor home stability, and having a lack of social support have all been shown to increase the likelihood if a re-hospitalization.

***Challenges 4:**

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

There are a substantial number of Medicaid recipients in the FLPPS region living with chronic conditions. The diagnoses with the highest prevalence among Medicaid beneficiaries include: hypertension (45,159); depression (37,880); asthma (22,251); diabetes (21,462); and chronic stress and anxiety (17,680). It should be noted that few individuals are hospitalized or die with a primary diagnosis listed of hypertension, yet high blood pressure is an important risk factor for heart disease, stroke, and kidney failure. Of additional consideration, diabetes disproportionately affects African Americans. For instance in 2010 – 2012, the region's African American population experienced 3,000 ED visits per 100,000 population, while whites had 1,100 diabetes ED visits per 100,000. In a perhaps related relationship, African Americans in the region die of kidney disease over twice as often as do white non-Latinos (30 deaths/100,000 vs. 13/100,000).

The FLPPS region has a significantly higher prevalence of mental illness among Medicaid beneficiaries (411.2/1000 pop.) when compared to the New York State (NYS) average (289.4/1000 pop.). In addition, the prevalence of substance abuse disorders is higher than the NYS average, with rates of 99.5/1000 population compared to 86.8/1000 population. Fifty-eight percent of current Medicaid recipients have had a behavioral health condition, for which they received treatment, at some point in their Medicaid claims history. In the FLPPS region, 50% of Medicaid recipients have a both a behavioral health and chronic disease diagnosis. Furthermore, in 2012, 65% of Medicaid or uninsured adults admitted to an inpatient medical or surgical bed had a co-occurring behavioral health diagnosis documented. The age-adjusted percentage of adults with poor mental health for 14 or more days in the last month is 11.9%, compared to a prevalence of 10.3% across all of New York State. In addition, the age-adjusted suicide rate is .31/100,000 population, which is worse than both the New York

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State average and Prevention Agenda goals.

The regional rate of newly diagnosed HIV cases is 6.8/100,000 population, better than the state-wide average. The regional also exceed the state average in rates of gonorrhea in women (206.2/100,000 pop), gonorrhea in men (186.5/100,000 pop), chlamydia in women (1601.8/100,000 pop), syphilis in men (2.3/100,000 pop) and Syphilis in women (0.3/100,000 pop).

***Challenges 5:**

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

The infant mortality rate in the FLPPS region has remained relatively stagnant over the last two decades, moving from 7.3 deaths per 1,000 births in 1994 to 6.4 deaths per thousand in 2011. Twenty-one percent of women reported smoking during or within three months prior to pregnancy, which is a risk factor for low birth weight. Allegany (8.9%), Monroe (8.7%) and Seneca (8.3%) counties have higher rates of low birth weight (< 2500g) when compared to the New York State (NYS) average (7.9%). Poor perinatal outcomes are the fourth leading cause of Years of Potential Life Lost in the FLPPS region, with rates higher than the Upstate New York average. Per regional SPARCS data, Medicaid infants (aged 0-1) utilize the ED 30% more than the non-Medicaid population. Gaps in substance abuse prevention services and healthy-pregnancy-habit education have resulted in seven FLPPS counties having a drug-related newborn discharge rate higher than the NYS State average (85 per 10,000 live births). Finally, only 65.1% of children, ages 0-24 months receive appropriate lead screening and 53% of children complete the 4:3:1:3:3:1:4 vaccination series.

***Challenges 6:**

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

The FLPPS region falls short of New York State prevention agenda goals for: adult obesity (29.9% vs. 23.%); adult smoking (21.1% vs. 15%); age-adjusted heart attack hospitalizations/10,000 population (17.3 vs. 14); and rate of hospitalizations for short-term complications of diabetes/10,000 population (7.21 vs. 4.86). In addition, nearly 9,000 beneficiaries chronically abuse alcohol and 7,400 are listed as having drug abuse as a chronic issue. The FLPPS rate of chronic alcohol abuse and chronic drug abuse are higher than the state's rate (28.1 vs 20.4 and 23.3 vs 16.9, respectively).

***Challenges 7:**

Any other challenges:

Homelessness is pervasive across the FLPPS region. Partner FQHC's report that in 2013, between 1% (rural areas) and 5.5% of their patients were either homeless or receiving public housing assistance. In the same year, the Monroe County DSS made 8,857 emergency placements for individuals and families, and increase of 6% over 2012. The second leading cause of homelessness (11% of cases) was release from an institution without a plan for permanent housing, including hospitals, substance abuse treatment programs or jail. Homelessness presents a tremendous burden to the regional health system, in terms of inappropriate use of services and poor health outcomes. Homelessness is particularly prevalent for those with a mental health or substance abuse diagnosis, as evidenced by FQHCs indicating that 58% of homeless patients are diagnosed with a behavioral health condition. As a result, 15% of inpatient mental health or substance abuse admissions were for individuals who were homeless at the time of admission.

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**.

While the FLPPS region has a large number of healthcare resources covering the full spectrum of acute, primary, long term, specialty and behavioral health care services, the system remains unbalanced. On one hand the PPS has determined an excess of at least 100 inpatient hospital beds and net excess of over 400 skilled nursing facility beds across the 13 county regions. On the other hand, there are wide-spread gaps in the PPS infrastructure that must be addressed to reduce inappropriate admissions and improve health outcomes, including:

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(1)Fragmented clinical services have led to high disease prevalence, poor health outcomes and siloed delivery of care; (2) Focus groups with high-utilizing Medicaid recipients noted that inadequate and isolated social supports, including insufficient transportation resources, lack of housing and low levels of health literacy are contributing factors to inappropriate ED use and low patient activation; (3) Disjointed implementation of HIT has left gaps in the flow and accessibility of health information; (4) Volume-based incentives inherent to a fee-for-service payment model are a barrier to promoting a model of care focused on value and health. To this end, there is a barrier in providing adequate reimbursement to providers and community-based programs offering chronic disease prevention and management services; (5) There are poor care transitions after discharge and lack of overall management, leading to high readmission rates; (6) There are inadequate rates of health literacy, particularly around a patient's understanding of illness and their role in medication management; (7) There is a lack of supportive housing services; (8) There are extensive gaps in access to primary care and behavioral health services, particularly driven by a shortage of licensed providers and inadequate transportation resources; (9) Long-standing silos between physical health, mental health and substance abuse have created service-level gaps for patients with comorbidities; (10) There are gaps in service capacity to support dependent elders, particularly those with a behavioral health diagnosis; (11) There is a lack of crisis stabilization services, including 24/7 outreach, ambulatory and intensive services. Focus group participants confirmed this assumption; (12) There is poor coordination of services for high-risk mothers, such as pyscho-social supports, transportation, health literacy and education about healthy behaviors. There is also a lack of attention to the causal factors of toxic stress and their effect on high risk pregnancies; (13) There is a gap in the availability of mental, emotional and behavioral (MEB) health prevention and promotion services; (14)There is a gap in the PPS's ability to assess and target high risk populations, while social and economic risk factors increase the probability of experiencing health disparities; and (15) There is a disconnect between the health system, ancillary support services like lab and pharmacies, and community-based programs.

***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.

With the evolution of modern medicine and technology there is a need for more ambulatory services and less acute care and SNF beds. This is problematic as the PPS has a lack of coordinated services as evidenced by the PQIs which are attributable to chronic disease (diabetes, respiratory, and heart) that account for 85% of all potentially preventable inpatient hospitalizations in 2012.

Furthermore, there is a lack of access to high quality primary care providers and behavioral health services. The FLPPS region has fewer physicians than the NYS average (62.45 /100,000 pop vs. 84.5/100,000 pop) and 12 of the 13 counties in the region are Mental Health HPSAs. Many primary care practices reported that they are struggling with PCP retention and recruitment. No-show rates across regional FQHC's ranged from 20-35%, and up to 50% for new patients. Low rates may reflect poor access to care or low patient satisfaction. There is higher patient satisfaction in practices with bilingual services and in practices with low provider turnover and, per the providers in the NOCNs, <40% of practices offer after hours services and only 20% offer weekend hours. Finally, only 52% of primary care providers are recognized as PCMHs

Other sources of capacity gaps include:
* Inadequate Income- 7% of all PPS residents has failed to seek care due to cost.
*Low rates of program implementation- per the NOCN focus groups, the Health Homes in the PPS have a wait list for care management access.
*Inadequate Housing- Housing was the top capacity priority identified, reinforcing the fact that the current available resources for the behavioral health population are insufficient.
*Inadequate Transportation- Focus group participants cited a lack of adequate and timely transportation as the reason for missing doctor's appointments, failing to adhere to a plan of care, and eventually being admitted to the hospital.
*Inadequate elder support services: Lack of elderly support services and poor transitions of care: The tertiary hospitals reported that 20% of their readmissions are from SNFs.

***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.

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In order to sufficiently address identified gaps and meet the needs of the community, the PPS must:
(1) Develop an Integrated Delivery System with interoperable data exchange, registries, and Care Management tools to manage and prevent chronic illness: A regional analysis of PQI admissions suggests that appropriate management of chronic conditions in the primary care setting, especially PCMHs, will result in improved outcomes and reductions in preventable utilization, over time. (2) Integrate physical and behavioral health care systems: Per traditional and entrenched paradigms, the FLPPS region separates the management of physical and behavioral health into distinct, non-integrated systems. Evidence suggests that developing integration between the behavioral and physical health systems will ensure that care is provided in a holistic and culturally competent way, thus improving outcomes and reducing avoidable high-cost admissions. (3) Address disparities around the social determinants of health: Key informants and focus group participants consistently highlighted social determinants of health as having a significant influence on the overall health status of the region's Medicaid population. Social determinants of health having an impact on the inappropriate utilization of services include transportation and housing. (4) Prioritize increased resources to support women and children: The delivery of community-based education and support services will have a positive impact on reversing poor health outcomes now and in the future. (5) Repurpose acute care facilities and develop ambulatory co-located services with additional primary care capacity, through new providers and open access and hours of operation along with consolidated services to create one stop medical shopping with partnerships with health homes and CBO's for care management, navigation, education and patient engagement will increase ability of patients to access care. (6) Train SNF in the INTERACT model to manage behavioral health issues to reduce readmission rates. (7) Cultural competency training will be crucial to support patient engagement in self -management and health literacy enhancement.

Section 3.7 - Stakeholder & Community Engagement:

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

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

The PPS's strategy for successful project selection and project development was widespread communication and the continuous solicitation of feedback, throughout application development. After the announcement of the DSRIP program opportunity, the four emerging PPSs in the Finger Lakes region convened numerous informational meetings with community stakeholders, including insurers, the Regional Commission on Community Health Improvement, FQHC representatives, public health officials, self-organized groups of providers, and a school of nursing. Subsequently, the emerging PPSs engaged the community (through five workgroups of service providers in geographic sub-areas, three Community Partner Engagement Meetings with over 240 attendees from interested organizations and providers, and a survey of 100 potential community partners) to examine preliminary data, identify perceived gaps in service, and begin to prioritize focus areas for the community.

After additional quantitative data analyses were conducted, data and results were shared with, and input was sought from, an even broader cross-section of the community through: two Project Advisory Committee meetings with a total of over 400 representatives from partner organizations and interested community members; six regional NOCN meetings with more than 170 potential participating staff from health care providers, community service providers, hospital/health system leadership, subject matter experts, patient advocates, and interested community members; a meeting with the Regional Commission on Community Health Improvement to broadly disseminate findings with community representatives; a Finger Lakes PPS website that provided background, updates, milestones, upcoming events, and the most recent version of the CNA for public comment; a public webinar on updates and next steps; 15 focus groups; 30 key informant interviews; and a web-based Community Services Survey to all known community service providers in the region, to identify resources, capacity, and barriers to utilization of services.

A more complete CNA and potential project list was then sent to the full list of potential FLPPS providers and stakeholders, and was posted on the FLPPS website for public comment. These comments were incorporated into the final CNA document.

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

In collaboration with FLPPS partner organizations, qualitative research was conducted in community settings with 15 focus groups of

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Medicaid recipients, Medicaid providers and high-risk individuals. Guided by preliminary findings of quantitative data analysis and stakeholder input, contributing populations included:

*Currently pregnant, first-time mothers
*Mothers of young children
*Individuals with behavioral health condition and history of hospital use
*Individuals with chronic disease and history of hospital use
*Individuals with substance use disorders and history of hospital use
*Individuals readmitted to hospital within 30 days of discharge
*Individuals with history of frequent emergency department use (not related to behavioral health condition)
*Migrant workers in rural counties

Focus groups were conducted across all NOCNs to capture differences between urban and rural populations. Questions were directed at challenges faced by the group, underlying causes of hospital use, and barriers to receiving needed care.

***Community 3:**

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

The FLPSS's broad-based stakeholder and community engagement process provided invaluable insights:
*Physical and mental health must be simultaneously addressed.
*It is difficult for individuals to find specialized mental health and/or substance use treatment throughout the area, and primary care physicians are ill-equipped to provide such comprehensive care.
*Socioeconomic factors are a driving force behind mental and physical wellbeing and struggles with chronic conditions.
*Individuals with chronic conditions are not receiving integrated care
*Transportation is the single greatest barrier to appropriately accessing care
*Gaps in transitions of care lead to poor health outcomes and high rates of readmission for homeless populations
*A disjointed implementation of health information technology has led to gaps in the flow and accessibility of health information, leading to poor health outcomes.

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.

[Finger Lakes PPS] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
1	Naturally Occurring Care Networks (NOCNs)	Geographically based networks of FLPPS partners based on shared utilization patterns	Because of the size of the FLPPS region, and the distinct needs of certain sub-areas within it, NOCNs provided feedback specific to their geographic areas.
2	Regional Commission on Community Health Improvement (RCCHI)	The RCCHI aims to improve health outcomes by facilitating the integration and coordination of programs and activities across nine of the FLPPS counties.	This is a large and very diverse group of community leaders whose endorsement and feedback were essential. They were also able to assist with broad dissemination of the preliminary CNA results.
3	County Health Departments	Provide a variety of services to Medicaid and uninsured populations	County Health Departments work in tandem with other health care providers and community agencies; FLPPS focus and activities will benefit from collaboration with them.
4	FLPPS Participant Advisory Committee	The structure and purpose of this committee was based on guidance given in DSRIP documentation from NYSDOH.	Partner organizations should be kept informed about, and have a say in, FLPPS strategies and developments.

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[Finger Lakes PPS] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
5	Healthcare and Community Service Organizations	Healthcare and community service organizations who were interested in the initial planning and strategizing related to DSRIP in our community (through meetings and surveys).	Involvement of community service organizations in planning is crucial in order to reach consensus on community needs, and to fully understand the supply, distribution and utilization of community resources and how they might be best utilized.
6	Greater Rochester Health Home of NY	Provide health home services in Monroe County	GRHHN can serve as a resource for providing coordinated and integrated health care.
7	Health Home of Upstate NY	Provide health home services in 11 out of 13 FLPPS counties	HHUNY can serve as a resource for providing coordinated and integrated health care.
8	Workgroups of service providers	Service provider groups who self-organized early in the DSRIP process	These groups self-organized in an effort to understand the DSRIP opportunity and risks, and to identify shared needs and concerns to be communicated to the FLPPS leads.
9	Finger Lakes Health Systems Agency	Regional health planning organization	FLHSA brings extensive experience in data analysis related to population, health care utilization, and health system capacity to FLPPS.
10	Focus groups	Medicaid recipients, Medicaid providers, and at-risk individuals	Understanding the health needs and perspectives of at-risk populations in our region is essential in developing a strategy that will address the health care needs, challenges and barriers of those populations.
11	Key Informants	Other stakeholders	To better understand the systematic perspective on the issues discussed in focus groups

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.

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[Finger Lakes PPS] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
1	The Burden of Chronic Illness	In the past, acute disease was the primary cause of illness and patients were generally inexperienced and passive recipients of care. Today, chronic diseases management is ultimately the responsibility of the individual. Most skills required for disease management are not disease specific, but life and behavior change skills. Data suggests FLPPS providers have not adequately managed this paradigm shift. The PQIs which are attributable to chronic disease (diabetes, respiratory, and heart) account for 85% of all potentially preventable inpatient hospitalizations in 2012. Furthermore, diseases of the circulatory, respiratory, digestive and endocrine systems account for 13,856 (almost 20%) of Medicaid hospital admissions. The most common causes of premature mortality across all population types include Cancer, Heart Disease, COPD and Stroke. These illnesses share a number of conditional risk factors including smoking, physical inactivity and unhealthy diet, which are widespread across the population: the FLPPS region falls short of New York State (NYS) Prevention Agenda goals for: Adult Obesity (29.9% vs. 23.2%); Adult Smoking (21.1 percent vs. 15 percent); Age-Adjusted Heart Attack Hospitalizations/10,000 pop. (17.3 vs. 14); and Rate of Hospitalizations for Short-Term Complications of Diabetes/10,000 pop. (7.21 vs. 4.86).	(1) Plumb, Weinsten, Brawner & Scott (2012); (2) NYS SPARCS Database; (3) NYS Advanced BRFSS, 2009
2	High Prevalence of Behavioral Health Disorders	The FLPPS region has a significantly higher prevalence of mental illness among Medicaid beneficiaries (411.2/1000 pop.) when compared to the New York State (NYS) average (289.4/1000 pop.) In addition, the prevalence of substance abuse disorders is higher than the NYS average, with rates of 99.5/1000 population compared to 86.8/1000 population. Regional rates of Poor Mental Health for 14 or More Days in the Last Month (11.9%) Adult Binge Drinking (16.1%) and Suicide (9.31/100,000 pop.) are higher than NYS Prevention Agenda goals. Fifty-eight percent of current Medicaid recipients have had a behavioral health condition, for which they received treatment, at some point in their Medicaid claims history. Five of the top 10 chronic disease diagnoses among PPS Medicaid recipients are behavioral health-related, and suicide is the fifth leading cause of Years of Potential Life Lost (YPLL) and the only cause trending upward since 2002. Those with behavioral health diagnosis are high users of health care services. Over 50% of active behavioral health super-utilizers were seen in the ED for general signs and symptoms at some point during 2013, while 44% were seen for injuries. Over 50% of all treat and release visits for chronic conditions are	(1)NY State Open Data; (2) NYS Advanced BRFSS, 2009; (3) NYS Salient Claims data; (4) NYS Vital Statistics.

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[Finger Lakes PPS] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		attributable to behavioral health diagnosis. Behavioral health disorders represent 17% of all Medicaid hospitalizations with a readmission within 30 days.	
3	Poor Health Outcomes for Women and Children	The FLPPS region experiences (1) poor pregnancy outcomes, (2) subsequent hospitalizations, and (3) poor maternal and child health through the first two years of a child's life: The infant mortality rate in the FLPPS region has remained relatively stagnant over the last two decades, moving from 7.3 deaths per 1,000 births in 1994 to 6.4 deaths per thousand in 2011. Twenty-one percent of women reported smoking during or within three months prior to pregnancy, which is a risk factor for low birth weight. Allegany (8.9%), Monroe (8.7%) and Seneca (8.3%) counties have higher rates of low birth weight (< 2500g) when compared to the New York State (NYS) average (7.9%). Poor perinatal outcomes as the fourth leading cause of Years of Potential Life Lost in the FLPPS region, with rates higher than the Upstate New York average. Per regional SPARCS data, Medicaid Infants (aged 0-1) utilize the ED 30% more than the non-Medicaid population. Gaps in substance abuse prevention services and healthy-pregnancy-habit education have resulted in seven FLPPS counties having a drug-related newborn discharge rate higher than the NYS State average (85 per 10,000 live births). Finally, only 65.1% of children, ages 0-24 months receive appropriate lead screening and 53% of children complete the 4:3:1:3:3:1:4 vaccination series.	(1) NYS Vital Statistics; (2) NYS SPARCS Database; (3) NYS Advanced BRFSS, 2009
4	The Burden of Homelessness	Homelessness is pervasive across the FLPPS region. Partner FQHC's report that in 2013, between 1% (rural areas) and 5.5% of their patients were either homeless or receiving public housing assistance. In the same year, the Monroe County Department of Health and Human Services made 8857 emergency placements for individuals and families, and increase of 6% over 2012. The second leading cause of homelessness (11% of cases) was release from an institution without a plan for permanent housing, including hospitals, substance abuse treatment programs or jail. Homelessness presents a tremendous burden to the regional health system, in terms of inappropriate use of services and poor health outcomes. Homelessness is particularly prevalent for those with a mental health or substance abuse diagnosis, as evidenced by FQHCs indicating that 58% of homeless patients are diagnosed with a behavioral health condition. To this end, housing was the top capacity priority identified by the County Directors of Mental Hygiene, reinforcing the fact that the current available resources for the behavioral health	(1)Western Region BHO's quarterly progress report; (2)County-specific Behavioral Health Service Plans; (3) FQHC Uniform Data System Reporting, 2013; (4) Monroe County Department of Social Services; (5) FLPPS Focus Groups

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[Finger Lakes PPS] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		population are insufficient. As a result, 15% of inpatient mental health or substance abuse admissions in the WRBHO 18 county region were for individuals who were homeless at the time of admission. Finally, focus groups highlighted that gap in transitions of care lead to poor outcomes and high rates of readmission for homeless populations.	
5	A Fragmented HIT Infrastructure	Disjointed implementation of Health Information Technology (HIT) has led to gaps in the flow and accessibility of health information: *The PPS includes at least 33 disparate EHR implementations and three RHIOs that lack interoperability. *Sixty percent of PPS partners do not share data with their local RHIO; *There are particular gaps among nursing homes and behavioral health providers. *Community-based organizations (CBOs) lack the HIT infrastructure to perform population health management.	(1) FLPSS Community Services Survey; (2) NOCN Planning Meetings
6	The Burden of Co-occurring Medical and Behavioral Health Diagnosis.	In the FLPPS region, 50% of Medicaid recipients have a both a behavioral health and chronic disease diagnosis. Furthermore, in 2012, 65% of Medicaid or uninsured adults admitted to an inpatient medical or surgical bed had a co-occurring behavioral health diagnosis documented. Having a medical and behavioral health comorbidity results in inappropriate system utilization. The WRBHO found that 77% of inpatient mental health or substance abuse admissions had a physical health need identified during the inpatient stay. Moreover, individuals admitted to an inpatient psychiatric bed with a secondary diagnosis of diabetes or heart disease had a 31% and 48% increase in the odds of being readmitted, respectively, relative to those without these comorbid conditions Focus groups participants who were interviewed due to a diagnosed chronic physical health condition frequently self-identified a need for simultaneously addressing both physical and mental health. Likewise, data on screening and treatment of diabetes among individuals with schizophrenia or bipolar disorders with and without the use of antipsychotic medications shows poor integration between behavioral and physical health.	(1) NYS SPARCS database; (2) WRBHO; (3) NYS Salient Database
7	Socio-Economic barriers to care	Literature suggests that one's social circumstances, health behaviors, and the physical environment all play an important and interconnected role in shaping one's health. For example, having an inadequate income affects many aspects of health, including access to care, ability to buy and eat a healthy diet, adequacy of housing. In fact, 7% of all PPS residents have failed to seek care due to cost. Being non-white, having low income, being	(1) Alder & Rehkoph, 2008; (2) Calvillo and King et. al., 2013; (3) NYS Advanced BRFSS, 2009; (4) FLHSA Regional Chart Book.

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[Finger Lakes PPS] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		unemployed, having lower education levels, having poor home stability, and having a lack of social support have all been shown to increase the likelihood if a re-hospitalization . Furthermore, Median ZIP code income is also an important predictor of readmission risk, with every $10,000 increase in median ZIP code income decreasing one's readmission risk by about 2%. To this end, 31% of the regional population has Low SES, earning less than 200% of the Federal Poverty Guideline (FPG); thirteen percent live in poverty. Poverty rates are highest in the city of Rochester but poor and near-poor live in all areas of the region. Racial and ethnic populations living in Rochester are especially affected by poverty. Almost two-thirds (65%) of African Americans and 69% of Hispanics have household incomes below 200% of the FPG. Also in the city of Rochester, over three-quarters (76%) of children, ages six and under, live in or near poverty.	
8	Uninsured, Non-Utilizing and Low-Utilizing Patient Populations	8% of FLPPS region's population is uninsured, with eight of 13 counties having uninsured rates higher than the upstate New York average (9.1%). High number of uninsured can be attributed to gaps in services and resources, particularly in rural counties where the percentage of uninsured can be as high as 36%, compared with 7% in Monroe County and 15.1% nationally. Additionally, available resources that can potentially serve the uninsured are disproportionately concentrated in urban Monroe County. Approximately 81,000 of the FLPPS's 684,000 ED visits in 2012 were delivered to uninsured individuals. The region also has 68,918 Medicaid recipients who are either low or non-utilizers of services. In 2013, over 42,000 enrollees had fewer than three Medcaid claims and 15% had at least one ED visit during the attribution period, while having no PCP visit.	(1) NYS Advanced BRFSS, 2009; (2) NYS Salient Data); (3) NYS SPARCS Data
9	Services in support of an Aging Population	From 1992 to 2012 the number of persons over age 65 has increased by nearly 40,000 and accounts for 15.4% of the region's total population. This growth has led to gaps in service capacity to support dependent elders, particularly those with a behavioral health diagnosis. Patients with a disposition status as "discharged to a Skilled Nursing Facility (SNF)" and/or a diagnosis cluster including behavioral health symptoms were significantly more likely to be readmitted to the hospital. Readmissions to acute care beds following a discharge to a SNF account for about 16% of all Medicaid readmissions with behavioral health symptoms among the top 11 "Most Frequent Primary Diagnosis Clusters at Readmission" for SNF Readmissions Between April 2013 and March	(1) NYS Salient Data; (2) NYS SPARCS Database; (3) US Census Bureau

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[Finger Lakes PPS] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		2014, roughly 40% of SNF patients had a behavioral health or substance abuse disorder diagnosis, compared with 32% across NYS. Furthermore, between July 2013 and March 2014, the percentage of SNF residents in the PPS with depression and/or anxiety symptoms increased, with eight SNFs having averages of worsening depressive and anxiety symptoms greater than the NYS average (11.6%), and 19 SNFs having averages greater than the national average (6%).	
10	Inadequate Transportation	CNA-driven focus groups identified transportation as the single greatest barrier to appropriately accessing care. A survey of behavioral health providers concurred. There is a mild and statistically significant negative association between distance from a hospital and the percent of active BH users in a ZIP code who received a hospital-based BH service in 2013, meaning that those who live further from a hospital might be less likely to use hospital-based BH services. For instance, in the focus group of urban residents who had been hospitalized with a chronic disease, participants twice cited a lack of adequate and timely transportation as a reason for missing doctor's appointments, failing to adhere to a plan of care, and eventually being admitted to the hospital. Among new young mothers, transportation surfaced as a crucial barrier to successful parenting. Most of the participants did not own a car, making it difficult to attend pediatrician appointments or travel to a full-service grocery store to shop for healthy food. Public transportation, while more readily available and affordable, was largely viewed as unfriendly to parents with young children.	(1) Focus Groups; (2) Geocoding warehouse; (3) Community Partner Survey; (4) NYS Salient Data
11	Cultural Competency	The majority of the racial/ethnic diversity is in Monroe County with 62% white, 22% African American, 6% Hispanic and a growing refugee resettlement program with over 5200 refugees from Bhutan, Burma, Somalia, Iraq and Cuba. The rural area includes hard- to-reach populations such as the Mennonite, migrant farm workers and the undocumented. The Finger Lakes FQHC data shows that 48% are best served in a language other than English. Additional cultural challenges include: large deaf population, high rate of developmental disabilities, American Indian tribes and the institutionalized population. Racial and ethnic disparities in readmission risk were found only in surgical inpatients, with blacks and Hispanics having 11% and 38% greater odds of being readmitted relative to whites. This suggests that special focus may be needed on providing culturally competent care, perhaps with particular consideration of English-language proficiency, at and around the time of discharge for surgical patients. Furthermore,	(1) U.S. Census Bureau; (2) Project Advisory Committee Meetings; (3) Community Partner Survey

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[Finger Lakes PPS] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		eight percent behavioral organizations cited language and culture are barriers to accessing services.	
12	Lack of Integration between Community Based Organizations and the wider health system.	A litany of community based organizations (CBO) that support individuals in the Medicaid and uninsured populations exist in the FLPPS region. Unfortunately, the availability of these organizations has remained somewhat shrouded from the health care community. Providers and public health officials present at the FLPPS stakeholder meetings identified that PCPs and hospitals lack good information about the availability of community-based programs and resources. Community-based services are currently separated from the wider health system, including those programs delivered by public health departments and offices of the aging. a survey of community-based service providers found that a lack of transportation was the most frequently cited barrier to individuals receiving necessary support. Another confounding factor is that community-based prevention services are often grant funded and unsustainable over the long term.	(1) NOCN Planning Meetings; (2) Community Partner Survey
13	A Shortage of Health Professionals	The FLPPS region has fewer physicians than New York State (NYS)(62.45 /100,000 pop vs. 84.5/100,000 pop) The Health Resources and Services Administration (HRSA) identifies Health Professional Shortage Areas (HPSAs) through an application process that documents need for a particular service. Within the FLPPS region Allegany, Livingston, Orleans, Seneca, Wayne, Wyoming and Yates counties are listed as entire counties with HPSA PCP designations. Further, Cayuga, Genesee, Monroe, Ontario, and Steuben counties contain PCP HPSA's for various portions of their population. The behavioral health workforce in the PPS region also appears to be inadequate. No PPS counties exceed the NYS average rate for either psychiatrists or psychologists. This lack of doctoral level practitioners may have serious implications. HRSA also identifies MH HPSA's Through this process Allegany, Chemung, Orleans, Seneca, Steuben, Wyoming, and Yates counties are all identified, in their entirety as lacking mental health services. Cayuga, Genesee, Livingston, Monroe, Ontario, and Wayne counties are also identified as having subsets of their populations in need of additional mental health services. These identified gaps in the mental health care workforce could present serious challenges to any programs targeted to the behavioral health population.	(1) Center for Healthcare Workforce Studies; (2) HRSA Data Warehouse

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.

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File Name	Upload Date	Description
9_SEC038_FINAL CNA Report 12-18-14.pdf	12/18/2014 11:59:58 AM	FLPPS Community Needs Assessment

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SECTION 4 – PPS DSRIP PROJECTS:

Section 4.0 – Projects:

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

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

Please upload the Files for the selected projects.

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

Currently Uploaded File: **Finger Lk_Section4_Text_FLPPS_DSRIP Project Plan Application _ Section 4_Final Edit_v2.docx**

Description of File

File Uploaded By: rghcfish

File Uploaded On: 12/22/2014 08:44 AM

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

Currently Uploaded File: **Finger Lk_Section4_ScopeAndScale_Section 4 - Speed and Scope - FINAL.xlsx**

Description of File

File Uploaded By: rghcfish

File Uploaded On: 12/22/2014 08:45 AM

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SECTION 5 – PPS WORKFORCE STRATEGY:

Section 5.0 – PPS Workforce Strategy:

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

The following subsections are included in this section:

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

Scoring Process:

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

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

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

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

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

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

Approximately 176,000 workers are employed by 600 organizations participating in FLPPS. Based on data from provider assessments, FLPPS estimates that 3% of the workforce will be impacted by redeployment (4,900), 12% (21,120) by retraining and <1% by reductions. Workforce Training occurs at 3 levels: (1) Grow employees along their professional development path (career ladder); (2) Prepare employees to do their current job in new ways (retraining); and (3) Prepare employees for redeployment to new roles.
FLPPS anticipates a change in staffing needs as a result of medical village transformations and an increase in the primary care foot print. The PPS also expects an increase in the need for many types of new staff as the organization increases capacity and creates new ambulatory, community and home care roles. Where possible, FLPPS will redeploy staff to support new positions created by increased

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patient demand in other care continuum areas.
To ensure FLPPS is staffed with the right people, with the right skills, in the right place, and at a sustainable cost, a comprehensive Finger Lakes Workforce Strategy (FLWS) will support employees through the changing workforce needs of the evolving system, and will ensure efficient, effective approaches to meet provider staffing requirements:
*Engage frontline staff to inform solutions and foster buy-in:
*Tailor cost-effective, quality training programs; scalable redeployment methodologies; and recruitment strategies informed by key stakeholders;
*Develop standard key competencies for roles/functions and training resources for redeployment and advancement;
*Work with local institutions to develop certification programs to support growth within disciplines and a means to shift to new disciplines;
*Create a centralized job board as a means for providers to communicate open positions and employees to search for them;
*Adjust the workforce model to address gaps in supply/demand in real time, through recruitment or rapid redeployment.
The FLWS will be operationalized in the 5 Naturally Occurring Care Networks (NOCNs) based on volume of need. NOCN workgroups will implement practice standards to support local realities and Medicaid member needs, while identifying and proposing local solutions for challenges and obstacles. Workforce metrics will be tracked on PPS and NOCN-level performance dashboards to support ongoing evaluation of workforce impact, needs and demands.
FLPPS expects the following positions to be impacted: registered nurses (including BSN) (N, RT, RD), licensed practical nurses (RT, RD), case/care managers (N, RT), IT staff (N, RT), social workers (N, RT, RD), administration (N, RT, RD), navigators (N, RT), community health workers (N, RT, RD), data analysts (N, RT, RD), nurse practitioners (FNP, ANP/GNP) (N, RT), primary care providers (MD, DO) (N, RT), physician assistants (N), project director (N), physicians (other) (N), psychiatrists (N), psychiatric NPs (N), psychologists (N), drug/alcohol counselors or addiction specialists (N), translators (N), home care aides (N), paraprofessional (direct care personnel, i.e. nurse assistants, patient care techs) (N, RT), dentists (N).
The drivers of change in the workforce are: 1) Aging, including physicians and particularly psychiatrists; 2) Reduced demand for inpatient acute care and nursing home beds with transition to managed care; 3) Increased need for health care workers in new/expanded roles: care navigation, peer/family health coaching, home/community-based long-term care/support services, integrated primary care and behavioral health management; 4) Changes in scope: ability to practice at "top of license," ability of NPs to practice independently starting in 2015 & expansions of scope of practice for other healthcare professionals; 5) Care redesign, expansions of select areas of care and performance improvement re-engineering.

***Strategy 2:**

In the response, please include

- Please describe the PPS' approach and plan to minimize the workforce impact, including identifying training, re-deployment, recruiting plans and strategies.
- Describe any workforce shortages that exist and the impact of these shortages on the PPS' ability to achieve the goals of DSRIP and the selected DSRIP projects.

The FLWS will be a win-win that proactively supports employees through the changing workforce needs of an evolving system, and assures efficient and effective approaches to the staffing requirements of providers.

FLPPS is committed to retaining its most valuable resource: human capital. To ensure the FLWS supports employee growth and minimizes adverse impacts, the FLPPS Workforce Operational Workgroup (WOW) will engage with a workforce strategy vendor with relevant experience to assist in developing and implementing the FLWS. The WOW has developed a Request for Applications (RFA) process to evaluate local vendors with demonstrated expertise in addressing workforce impact.

As is illustrated in the CNA, the healthcare workforce in the FLPPS region has significant shortages. The majority of counties have lower than New York State (NYS) average per capita patient care providers. The total physician workforce is lower than NYS average in all counties but Monroe, where the lead organizations and major medical centers are located. 11 of 13 counties are designated Health Professional Shortage Areas (HPSAs) for primary care providers. 11 of 13 counties are also designated mental health HPSAs, and all FLPPS counties have psychiatrist and psychologist presence below NYS average, most acutely in rural areas. By assisting providers to redesign internal operations through process improvement methodologies, the PPS may be able to expand patient panels of existing providers, especially in rural areas. FLPPS has identified that in some counties, RN and nurse practitioner distribution is above NYS average. FLPPS will seek to leverage this resource via FQHC expansion and other DSRIP initiatives.

Expansion of primary care across PPS FQHCs via Project 2.a.i, and primary care and behavioral health integration in Project 3.a.i, are the initiatives most likely to be impacted if we are unable to expand our cadre of primary care and behavioral health providers. The current

lack of multilingual and multicultural behavioral health providers exposes the limitations of retraining and redeploying existing staff and underscores the importance of an expanded workforce. ED care triage (Project 2.b.iii) would also be adversely affected if the current primary care shortage persists and providers are unable to expand urgent care and open access scheduling, threatening the ability of FLPPS to move care from institutional to ambulatory, home- and community-based settings. The PPS will do a thorough assessment of PCP and dentist availability, panel size and capacity over the coming months to gain a better understanding of the gaps, and work to design innovative means for addressing them.

Due to an existing workforce shortage, development of expanded care navigation, care management and peer health educator positions for projects such as 2.b.iv and 3.a.ii will require introduction of new training programs and the ability for current workers to take advantage of retraining and redeployment opportunities. For example, unit secretaries, patient care technicians/nurse's aides and patient transporters may be eligible for retraining as medical assistants for expanded primary care sites or as care navigators/panel managers to enhance bandwidth to allow for 30-day follow-up of discharged patients. There is an urgent need for training of physical health providers such as NPs to become certified in behavioral health care and sharing behavioral health resources across the varied FLPPS landscape to make up for gaps in the most strained areas.

***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	3%
Retrain	12%
New Hire	1%

Section 5.2 – WORKPLACE RESTRUCTURING - RETRAINING EXISTING STAFF :

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

Description:

Please outline the expected retraining to the workforce.

***Retraining 1:**

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

The FLWS will first assess current workforce skills and capacities needed to meet DSRIP goals to establish a comprehensive gap analysis. This will require an assessment of new knowledge, skills and abilities (KSA) needed. The next step will be to identify existing positions that can be expanded or repurposed based on job function changes. Once positions have been targeted, the skills and competencies of needed positions will be identified and an appropriate training modality will be evaluated. Other areas of consideration include motivation and availability of the employee and support and involvement of local leadership. Principles of adult learning will be incorporated into all training design.

Training resources: A survey of providers indicated multiple in-house training resources and protocols. The majority expressed openness to centrally coordinated training. The primary care and behavioral health integration project can utilize the training program embedded within the IMPACT model. The Coleman model trains care managers participating in the care transitions intervention. The INTERACT model can serve the behavioral intervention paradigm in nursing homes via essential skills training components such as dementia and palliative care. Other programs adapted or developed by local providers will be assessed and adapted as appropriate. FLPPS will support additional training options to its partners by maintaining a catalogue of relevant training resources and offering targeted, instructor-led training for each NOCN.

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A training vendor/instructional designer will work with project teams to identify required position competencies, develop standard position descriptions, and define knowledge gaps and content/approaches to best meet training and redeployment needs for high-volume positions such as community health workers. Approaches might include a recommended set of offerings to support development of the required KSAs, including offering ILT/train-the-trainer sessions. The WOW will also identify and develop core key competencies that cut across many positions and develop recommended resources for developing each of the key competencies. This will allow for a "modular" approach to KSA development and facilitate career growth and redeployments.

The region's two largest local academic centers, University of Rochester and Rochester Institute of Technology, are partners in the FLPPS and discussions are underway exploring certification and/or continuing education offerings that will be needed, e.g. specialized behavioral health training for clinical providers such as nurses.

The FLPPS will engage in educational planning at the PAC level at least quarterly during DY1, at which DSRIP providers and participating staff will share the results of their work and discuss innovative solutions. The first PAC planning summit is scheduled to take place in January. At the summit, workgroups will be assembled to map out the next 5 years of the FLPPS. Summit frequency post-DY1 will be discussed in Q4 DY1.

Nearly 17% of providers indicated that current positions required additional training that would be mandatory for most employees participating in DSRIP project implementation, while 13% said most employee training would be voluntary. FLPPS will offer change management workshops to leaders within participating organizations to equip them with tools needed to communicate the need for training in a way that engages and motivates employees.

One motivational strategy to increase participation in training is to support organizations in offering CEU/CNE/CME for required training where possible. The workforce strategy vendor will help develop policies and procedures to address implementation/enforcement. The WOW is also working to engage partners to identify incentives for staff who engage in voluntary training.

***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.

Based on the preliminary assessment, 33% of providers believe there will not be significant changes in employee wages and benefits while 3% of performing providers anticipate an increase in salary as a result of retraining. The remaining providers indicated no change or were unsure how the retraining would impact salaries. Cross-functional training will be an important focal point for regional and oversight work-groups, ensuring an allocation of resources at the right time in the right setting. While the PPS anticipates minimal impact to compensation in the early years of DSRIP, it is not yet clear how shifts in location and level of care delivered will be balanced by increases in the population served due to the efforts of Project 2.d.i. The workforce strategy vendor will help develop strategies, policies and procedures for managing these shifts in position type and quantity.

FLPPS anticipates more staff to be employed in positions other than the current matrix as the region progresses away from densely staffing acute and long-term care (which historically requires more specialized training and experience) to support population health and preventive care models.

***Retraining 3:**

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

FLPPS is committed to minimizing adverse impacts to current employees as a result of DSRIP initiatives, and will encourage all PPS partners to find roles for employees who want to remain. FLPPS is engaging a workforce strategy vendor to develop strategies, policies and procedures for providers to use in these situations. With a regional leadership and staff empowerment approach, FLPPS anticipates employers will plan to drive retraining assignments considering areas of need & employee talent, given project requirements.

In the event of refusal, performing providers reported in a preliminary assessment they:
*Did not anticipate any refusals
*Would offer alternative solutions to employees
*Would follow existing HR policies, procedures and regulations to address retraining refusal issues.

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***Retraining 4:**

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

Whereas the number of FLPSS partner organizations with organized labor is relatively small, the labor union representatives of these partners have been invited and engaged in PAC meetings, NOCN workgroups and planning sessions to ensure close integration with the appropriate stakeholders during the planning period. As the PPS develops its retraining plan, the organization will rely on the experience and expertise of labor representatives to ensure deployment of best practices in retraining strategies. Specifically, labor representatives will be critical in helping FLPPS understand readiness, potential obstacles for retraining entry-level employees, and informing solutions. Through NOCN planning sessions, labor representatives will help flag regionally specific best practices to ensure the retraining plan is tailored to meet the unique needs of employees throughout each NOCN.

***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	22%
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.

FLPPS anticipates redeployment to be an evolving process over the course of DSRIP. FLPPS will partner with its workforce strategy vendor to create a comprehensive FLWS that will include detailed plans for how to proactively identify, communicate with and guide through a redeployment process, those employees who may be impacted by downsizing, changes in position workflow, revised licensure requirements/expansion in licensure or certification scope, and availability of new position opportunities.

As a first step, the FLPPS will develop guiding principles for redeployment within an organization, and policies around employee redeployment into an organization other than their own.

Secondly, to address immediate redeployment needs, FLPPS plans to implement a centralized job board that will serve as a site for performing providers to list positions they have open or anticipate opening along with associated competencies required for the positions. This will provide employees with easy access to available opportunities within their range of qualifications.

NOCN workgroups will evaluate available resources across all settings of participating organizations. A comprehensive menu of available competencies and positions matching those competencies will be developed in order to determine gaps in committed resources. Utilizing the job board, providers will identify employees who voluntarily express interest and are eligible to fill those positions and make recommendations to the NOCN workgroups.

***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.

About 40-50% of participating providers do not expect salary changes as a result of redeployment, at least in the near term and within their own organization. It is unclear how shifts will impact the salaries of current employees whose roles may change and/or who may be redeployed. FLPPS' intent is to minimize negative impact to individuals through encouraging and providing access to continuing education and competency development to support career growth and lateral redeployment. For example, registered nurses from hospital units being decommissioned and/or transformed into other care delivery models may be offered training as a psychiatric nurse specialist or a lateral redeployment to an area of the PPS in which there is currently a shortage of hospital beds and a need for nurses to staff new

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capacity. Centralized job board postings will be an important part of this strategy. This will also be an area of focus for future planning in partnership with the workforce strategy vendor and finance committee, performing analyses into potential salary changes for redeployed staff and how salary reductions can be minimized through job matching and targeted training and certification.

***Redeployment 3:**

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

FLPPS is committed to minimizing any adverse impact to current employees as a result of DSRIP initiatives, and will encourage all partners/providers to find a role for employees who want to remain within their organization. FLPPS will engage its workforce vendor to develop strategies, policies and procedures for providers to use in these situations.

Providers reported in a preliminary assessment that they:
*Did not anticipate any refusals
*Would offer alternative solutions to employees
*Would follow existing HR policies, procedures and regulations to address redeployment refusal issues.

When possible, redeployments will be voluntary. However, most anticipated redeployments will be unavoidable, and therefore mandatory, such as in situations where facilities are closing or being repurposed.

***Redeployment 4:**

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

Whereas the number of FLPSS partner organizations with organized labor is relatively small, the labor union representatives of these partners have been invited and engaged in PAC meetings, NOCN workgroups and planning sessions to ensure close integration with the appropriate stakeholders during the planning period. As the PPS develops its redeployment plan, the organization will rely on the experience and expertise of labor representatives to ensure utilization of best practices in redeployment strategies. Specifically, labor representatives will be critical in helping FLPPS understand readiness and potential obstacles for redeploying entry-level employees, and will inform solutions. Through NOCN planning sessions, labor representatives will help flag regionally specific best practices to ensure the redeployment plan is tailored to meet the unique needs of employees throughout each NOCN, especially in those where entry-level employees are being redeployed from hospital settings to ambulatory, community and home care settings.

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.

FLPPS anticipates the following types of jobs to be created, to ensure successful implementation of the selected DSRIP projects, including degree and license requirements, where applicable:

- Medical Assistants - prepare patients for their visit with the provider and assists provider during the visit. Allows clinical staff to work at the top of their licenses by doing these lower skill level functions. Anticipate using in primary care sites. Certificate required.
- Administrative staff - perform clerical duties. No degree or license required.
- Licensed practical nurses - provide basic nursing functions and can be utilized in settings/for roles that do not require RN duties. Allows RNs to function at top of their license, extending their reach. Anticipate using in primary care sites. Degree and license required.
- Licensed clinical social workers - provide mental health counseling at primary care and other sites. Degree and license required.
- Registered nurses - provide routine nursing functions at primary care and behavioral health sites. Degree and license required.
- Registered nurse case managers - plan and coordinate care. BSN degree required.
- Care manager - plan and coordinate care. LMSW and license required.
- Care coordinator - plan and coordinate care. BS required.
- IT analyst - software and system analysis. Will be used to implement EHRs, telehealth and develop analytics. Bachelor's degree in

computer science related field required.
- Navigators - work with the uninsured to help them connect with and get health insurance. AA degree required.
- Community health workers - support Medicaid patients in accessing services they need. Lay community members, no degree required.
- Primary care providers and advance practice professionals - will provide primary care at primary care practices. Degree and license required.
- Psychiatrists - behavioral health evaluation. Degree and license required.
- Physician assistants - patient evaluation in support of psychiatrist. Degree and license required.
- Psychiatric nurse practitioners - mental health assessment. Degree and license required.
- Business intelligence analysts - data collection and reporting. Degree required.
- Family/Peer bridgers - assist families in accessing mental, emotional and behavioral health providers. High school diploma required.
- Project coordinators - coordinate all DSRIP projects. Master's degree required.
- Physical therapists - examination and treatment. Degree and license required.
- Dental care managers - work with ED through referral process to engage uninsured people who use the ED for dental emergencies, to enroll them in insurance, insure that they understand dental care, and have transportation. Licensed dental hygienist.
- Transporters - provide transportation for patients to appointments.

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	150
Physician	46
Mental Health Providers Case Managers	291
Social Workers	100
IT Staff	120
Nurse Practitioners	46
Other	184

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	1,627,240	2,429,660	2,501,133	2,475,856	2,466,111	11,500,000
Redeployment	585,806	874,678	900,408	891,308	887,800	4,140,000
Recruiting	590,538	1,083,118	1,300,272	1,294,205	991,867	5,260,000
Other	350,896	671,864	700,453	690,342	686,445	3,100,000

Section 5.6 – State Program Collaboration Efforts:

***Collaboration 1:**

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

In a preliminary assessment of FLPPS providers, the PPS identified the availability of over 30 state programs active within the region that offer workforce recruiting, retention, or retraining opportunities. The four programs that were referenced most frequently by our providers were Area Health Education Centers (AHEC), Health Workforce Retraining Initiative, Doctors Across New York (DANY), and Physician Loan Repayment.

A representative from Rural AHEC has been invited to join the WOW given their expertise in the unique challenges our PPS faces as a result of its urban/rural makeup. AHEC is currently focused on meeting health workforce shortage needs in the most affected counties

throughout our region. FLPPS will ensure that these comprehensive training programs are built into its strategy for meeting workforce shortage needs in order to achieve successful DSRIP outcomes.

To ensure FLPPS adequately leverages and utilizes other existing programs that have been identified, the WOW will establish and implement a subworkgroup of key professionals from partner organizations who have had oversight of these programs within their respective organizations and can speak to best practices and integration with DSRIP objectives.

The WOW State Program Subworkgroup will be tasked with designing a process by which all state programs are compiled, reviewed, and linked to the FLPPS FLWS. The subworkgroup will design a workplan to ensure existing programs are integrated into current efforts and that best practices are shared across partners, as appropriate. The WOW Subworkgroup will also be responsible for regular monitoring of funding periods, workplan implementation, and outcomes for the integration of current programs with the FLWS. The subwrokgroup chair will present findings at the FLPPS Quarterly Summit and engage workgroups during FLPPS to refine the workplan, as needed.

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 PPS engaged providers, employees, labor representatives and subject matter experts to develop a comprehensive understanding of impacts to and needs of our workforce, and gathered perspectives on how to address them. The WOW began meeting weekly in early November. The FLPPS team sent out a supplemental workforce assessment to all providers to collect data.

The executive team assigned the WOW co-chairs from regional academic institutions. Through nominations submitted by FLPPS partners, the co-chairs identified workgroup members from various care settings. The candidates were approved by the Executive Steering Committee. Members were offered a seat on the WOW workgroup meeting weekly at the FLPPS PMO office. Members of the WOW are executives, clinical providers, community-based organizations, human resources, and learning and development professionals. The WOW is responsible for designing the high-level strategy and vision of the FLPPS healthcare workforce.

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

Due to the small representation of the organized labor workforce, human resources representatives are primary points of contact for FLPPS employees and thus two of the WOW members are HR representatives. FLPPS has identified a human resources representative to coordinate with the various unions regarding representation on the FLPPS PAC. To engage the union groups in FLPPS planning process, letters were sent in August requesting that key contacts be identified from labor groups representing PPS partner organizations. In response, unions have identified 11 contacts within four labor groups (SEIU 1199, CSEA/Federation of Social Workers, CSEA/NYSNA, RWSDU Local 200) representing nearly 1,500 employees. All contacts have been engaged through PAC activities over the last four months.

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

Engagement of frontline workers is critical to ensuring that implementation plans are feasible, will drive intended results and will foster workforce engagement. The FLPPS PAC includes non-managerial staff who have been engaged in the planning process.

As the PPS moves into implementation planning, PAC Project Teams will expand to include more frontline workers and midlevel leaders. In order to ensure frontline workers are able to participate in implementation planning, providers will need to relieve these employees of other duties for up to eight hours a week. Implementation planning must become part of their duties, rather than adding to them.

To engage this new cadre of the workforce in implementation planning, the PPS intends to hold kickoff meetings with each NOCN to level-set and integrate newer participants with those who have been involved in the application design workgroups. These meetings will also

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outline the structure and process by which the workgroups will be supported in developing implementation plans.

***Engagement 4:**

Describe the steps the PPS plans to implement to continue stakeholder and worker engagement and any strategies the PPS will implement to overcome the structural barriers that the PPS anticipates encountering.

The WOW has developed the key components of the PPS engagement strategy. During the implementation planning phase, the PPS will develop a detailed workplan. Key elements of the engagement strategy include:
*Increase frontline and first-level leader participation
*Provide "Leading Change" and "Change Management 101" workshops for providers to support leaders in engaging their workforce
*Develop formal communication plan, including resources for providers to engage their employees: PPT presentations about DSRIP and FLPPS, leader meeting guides and talking points when holding meetings with staff, materials and handouts such as newsletters to distribute to employees
*Anonymous needs assessment surveys during staff meetings
*Quarterly meetings with providers (separate meetings with each NOCN) to share best practices, brainstorm together about current challenges, and share information
*Maintain the FLPPS website as a source of information and resources for all workforce levels

Section 5.8 - Domain 1 Workforce Process Measures:

Description:

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

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

Please click here to acknowledge the milestones information above.

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

DSRIP PPS Organizational Application

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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.

FLPPS' goal is to facilitate the exchange of pertinent patient information across the PPS network, for authorized purposes, to improve the quality, coordination and efficiency of patient care. Concurrently, FLPPS will ensure the protection of patients' privacy and data security in compliance with NYS and Federal regulations. FLPPS will ensure that network partners agree to comply with policies and procedures regarding the access and use of patient PHI. The Corporate Compliance Officer and IT Operations Committee will monitor the data sharing and confidentiality practices of the PPS. In all situations, electronic forms of PHI will be the strongly preferred medium. Any paper-based partners will be requested to explore electronic methods of capturing patient information. The three RHIOs with regions overlapping with the PPS will manage processes and training for obtaining and recording RHIO consent and exchanging information, and will serve as a hub of the regional health information.

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

PPS Partners will all be required to sign BAAs and Participation Agreements. The IT Operations Committee will develop applicable policies and procedures related to the restriction of individual access to PHI to the minimum necessary to accomplish the objectives of the PPS; electronic data security measures; and mitigation measures in the event of breach. Participants will be required to formally confirm their acknowledgement of these policies and procedures and their ability to comply. Each participant will be required to complete an annual survey demonstrating their compliance with industry standards related to the protection of PHI in all forms. Participants will identify an individual who is knowledgeable regarding HIPAA privacy provisions and demonstrate competency through annual training opportunities developed by the IT Operations Committee. The Corporate Compliance Officer will monitor privacy program risk and audit, as necessary.

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

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Through engagement with FLPPS providers, the PPS IT Operations Committee has identified two primary paradigms of data sharing that are necessary to ensure that patient needs are met: "Care/Referral Management" and "Care Delivery." Care/Referral Management is episodic in nature and focuses on navigating patients between care settings. While not all members of the PPS are clinical providers with EMRs, FLPPS will need to achieve a connected state across all partners. The PPS expects to close gaps by evaluating existing processes for Care/Referral Management with the goal of implementing a unified, real-time platform for PPS-wide deployment. The tool(s) would provide web-based connectivity for all providers to make real-time placement decisions, and would aggregate all FLPPS referral data for simplified integration with the local RHIO/SHIN-NY.

The Care Delivery paradigm is longitudinal in nature and focuses on a comprehensive understanding of patient medical history and condition. Providers who have existing EMRs will be engaged to integrate with RHIOs, making data available to PPS providers for patient care, and providing analytics in alignment with the established DSRIP data sharing model proposed by NYSDOH, which utilizes an opt-out paradigm. Providers without EMRs will be engaged to evaluate and overcome implementation barriers by providing guidance in selecting/deploying an EMR that meets the DSRIP-related requirements.

These changes will impact clinical workflows and workforce/training. The IT Committee strategy to address this challenge involves regular, frequent, structured sessions with the PPS Operations Clinical Committee and Workforce Workgroup to define and validate requirements. Specific use-cases/protocols with clearly outlined and approved data sharing requirements will be developed for each type of transition, and privacy agreements/system development will align with the approved use-case scenarios.

Section 6.2 – Rapid-Cycle Evaluation:

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

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

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

The CIO, reporting to the CEO, will be tasked with ensuring the PPS has access to NYS- and PPS-created metric data for each partner organization and provider, and is generating metric reports. The IT Committee, Clinical Committee, Chief Medical Officer (CMO) and CIO will establish a Data and Measures subcommittee to support the development of data reporting requirements and to ensure timely delivery of monthly data summaries to the appropriate Operations Committees.
With direction from the CMO, reporting to the CEO, Performance Improvement (PI) staff will be focused on defining, rolling out, and supporting centralized processes and procedures related to project management and performance improvement. The PMO and PI team will work closely with the Executive and Operations Committees in evaluating topic-specific data, establishing courses of action and implementing improvements across the network. Organization metric reports, updated monthly, will be distributed via cloud-based dashboard allowing organizations to view their score and benchmark against other regional providers and the PPS.

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

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

A consolidated view of the patient population is an essential building block for quality and performance improvement initiatives. To that end, FLPPS will implement a data management system to compile key data from claims and clinical sources, which relate to DSRIP quality and utilization metrics. This system will include analytics necessary for building patient registries to support condition management (e.g. diabetes), high-risk/high-cost patient identification, as well as the corresponding process and outcome measures logic. A data model

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that links patient interactions and outcomes to FLPPS partners and providers will allow performance evaluation and reporting to governance participants. Additionally, decision support tools will be provided to enable rapid identification of improvement opportunities and best practices. To establish real-time exchange of performance gaps amongst partners the PPS will establish a dashboard portal that displays an organization's score with benchmarks.

***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).

As indicated above, activities of the FLPPS Operations Committees and Workgroups (IT, Workforce, Finance, Clinical, Transportation, Housing and Cultural Competence) will be governed by the Executive Steering Committee. As jointly determined by the Executive Steering Committee, the PMO and PI office, and the Data and Measures subcommittee, each operational committee/designated member will be responsible for interpreting results, based on the data provided, and developing response strategies to improve metrics.

Beyond basic dashboards/balanced scorecard, FLPPS will implement a cloud-based tool to support interaction with the provider community. Key components of the tool will include the ability to foster collaboration with and among, providers, as well as capture and share data related to performance against key metrics.

***RCE 4:**

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

As the transition from fee-for-service to pay-for-performance accelerates, the rapid accumulation and evaluation of data, and the necessary corrective action that comes from that evaluation, becomes critical. As such, our approach to performance management will be defined as agile. Opportunity improvements will be reviewed and evaluated by the PI Office. Incremental change will be implemented and outcomes evaluated against defined clinical and financial metrics. Results will drive further cycles of iterative change. This approach will allow us to better gauge progress and quality, and provide feedback and adaptation for continuous improvement. Weaving performance management into the fabric of all participating providers, through leadership by FLPPS, is critical to achieving the Triple Aim of "simultaneously improving the health of the population, enhancing the experience and outcomes of the patient, and reducing per capita cost of care for the benefit of communities."

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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.

FLPPS is a large 13-county region with approximately half of the population residing in an urban center, Monroe County, and the rest dispersed in mostly rural settings. The majority of the racial/ethnic diversity is in Monroe County with 62% white, 22% African American, 6% Hispanic and a growing refugee resettlement program with over 5200 refugees from Bhutan, Burma, Somalia, Iraq and Cuba. Also from the CNA, Monroe County is not merely racially and ethnically diverse but has a high concentration of poverty driving stigma, distrust, high crime, poor graduation rates and conflation of authority between the law and health care.
Rural areas include hard to reach populations such as the Mennonite, migrant farm workers and the undocumented. Finger Lakes FQHC data shows 48% prefer a language other than English. Additionally cultural challenges include: large deaf population, high rate of developmental disabilities, American Indian tribes the institutionalized population, and a growing elderly population-from 1992 to 2012 persons over age 65 increased nearly 40,000, accounting for 15.4% of the total population.
Language and culture are consistent barriers to care, resulting in significant disparities in life expectancy and poor health outcomes for diverse ethnic, racial and cultural groups. Socioeconomic status, age, geographic location, religious affiliation and disability status also drive disparities. Large Medicaid and uninsured populations and urban/rural composition present a number of complex, unique challenges in addressing cultural barriers to positive health outcomes: (1) Lack of baseline knowledge of organizational performance due to lack of data; (2) Limited data available in FLPPS on race, ethnicity and primary language of our population served; (3) Limited data on health literacy rates specific to our region, and (4) Insufficient numbers of culturally and/or linguistically competent staff.

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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.

The FLPPS Strategic Plan to address cultural competency includes the achievement of health equity- reducing health disparities and improving health outcomes by developing and executing strategies that will promote a robust network of culturally responsive staff, culturally tailored health care settings and health literacy education initiatives for the PPS target population. The FLPPS will accomplish these goals by finalizing the membership of the Cultural Competency and Health Literacy Workgroup, which reports directly to the Executive Steering Committee. This Workgroup will ensure that cultural responsiveness and competence are included in the vision, goals and principles of FLPSS. In addition, this workgroup will: (1) Establish a baseline knowledge of system performance outcomes related to cultural competence; (2) Collect data on race, ethnicity and language in order to stratify and share information and collectively design targeted interventions to improve health inequities; (3) Develop/modify standardized assessment tools and culturally tailored training programs for the workforce; (3) Oversee the development of a workforce that is representative of the community; (4) Partner with local colleges to train the incoming health workforce on cultural competency and inform on-going professional development; (5) Develop, implement and monitor a set of policies, procedures and processes designed to account for the influence of educational attainment, income and other socioeconomic conditions on health risks in the entire population, and that enable caregivers to work more effectively across multi-cultural and multi-disciplinary situations; (6) Gather feedback from FLPPS's diverse population on progress on to reduce health disparities in order to necessitate change.

***Competency 3:**
Describe how the PPS will contract with community based organizations to achieve and maintain cultural competence throughout the DSRIP Program.

Robust collaborations between CBOs and FLPPS clinical providers will be vital to developing the goal of a culturally competent integrated delivery system. The FLPPS has identified a high level listing of community-based resources that can be utilized to engender cultural competency building activities and goals. As part of the DSRIP project implementation, FLPPS will evaluate where resources exist and where they might be developed. FLPPS will engage and contract with CBOs, acknowledging their unparalleled insight into the population served.
FLPPS will partner with CBO's that have existing models of care to promote cultural competency and health literacy, and will adopt these best practices. As an example, a local home care agency has a transcultural training program that offers insight on refugee health care views – 'Doctors have high social status so the patient may not be comfortable questioning them or expressing dissatisfaction with their treatment.' CBOs will also be leveraged to educate PPS patients, the consumers of healthcare, on the value of preventative care. In addition, in partnership with the region's extensive network of research institutions, the FLPPS will review and utilize existing models of CBO patient engagement that have been shown to be effective regarding cultural competence and health literacy.
To ensure sustainability of necessary CBO-delivered programming, the FLPPS will engage in contracts with CBOs to receive value-based payment for services. This will necessitate the development of standardized performance measurement, in terms of cost, quality and patient outcomes. FLPPS will require CBOs to collect data and assure transparency of results to evaluate and further plan cultural competency strategies. The PPS will support this strategy through the deployment of a community-based, integrated IT solution.

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:

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

According to the National Assessment of Health Literacy, only 12% of adults have proficient Health Literacy (HL). Though there is no data on regional HL, lower HL scores have been tied to poverty, which is regionally pervasive -- all counties have a per-capita income below the NYS average and 12 out of 13 counties have greater than 10% of their population living below the poverty threshold. Populations most likely to experience low HL rates include older adults, racial and ethnic minorities, people with less than a high school degree and individuals with a compromised health status. FLPPS is comprised of a large racially and ethnically diverse population. Cultural nuance is also driven by urban vs. rural local education. The percent of the population with a high school degree or less ranges from over 52% in Allegany County to about 36% in Monroe County; only two counties (Monroe and Ontario) have a rate that is less than the New York State average. Those with limited access to care, such as the uninsured, are also more vulnerable to lower HL scores. Furthermore, in a national survey of adults Medicare and Medicaid recipients, 27% and 30% had below basic health literacy, respectively, suggesting that even those exposed to the system are not being adequately empowered to make the correct health-related decisions. Furthermore, critical health information such as prescription labels and discharge instructions often contain difficult vocabulary or complex concepts at, or above an eighth grade reading level.

The FLPPS Strategic Plan for improving HL includes a Cultural Competency and Health Literacy Workgroup that reports directly to the FLPPS Executive Steering Committee. Efforts will be made to foster collaboration between this wokgrip and the Operations Clinical Committee. FLPPS will ensure that HL is part of the vision, principles and goals of the organization. HL initiatives include: (1) Collecting standardized data on race, ethnicity, reading skills, learning style preference and English language proficiency, to develop and implement targeted HL interventions; (2) Working with CBO's and their population served to increase HL; (3) Utilizing/hiring health navigators that understand the population served in order to overcome HL and improve health outcomes; (4) Developing and disseminating appropriate multilingual HL tools such as post discharge care instructions and healthcare resource guides using evidence based approaches; (5) Developing policies, procedures and processes on HL, based on best practice framework including: standards, implementation of services and evaluation measures; (6) Incentivizing organizations to be health literate; (7) Developing/modifying existing standardized assessment tools and training programs for the workforce on HL; (8) Creating a HL public using social marketing techniques.
FLPPS will partner with CBOs to help achieve the organization's HL goals, acknowledging their intimate knowledge of the PPS patient base. Insight offered by CBO partners will inform PPS policies and procedures. For example, input from developmental disability providers will drive best practice implementation around the use of visual symbols to convey health information will be utilized. As previously noted, in an effort to ensure sustainability of necessary CBO-delivered programming, the FLPPS will engage in contracts with CBOs to receive value-based payment for services. This will necessitate the development of standardized performance measurement, in terms of cost, quality and patient outcomes. FLPPS will require CBO'S to collect data and assure transparency of results to evaluate and further plan HL strategies. The PPS will support this strategy through the deployment of a community-based, integrated IT solution.

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 FLPPS funds flow plan establishes five budget categories: 1) An Administrative Fund will cover the costs of staffing the Project Management Office (PMO), PMO operations, and cost of DSRIP project implementation, including the development and management of centralized services. 2) A Contingency Fund will cover needs for non-covered services, high-cost niche populations, population health expertise, termination of existing state funding streams, and unforeseen levels of utilization. 3) A Partner Share of Funds, representing the majority, will flow to the FLPPS providers and partners who are engaged in the work and produce desired results, including a sub-allocation for CBOs that do not have attributed lives. 4) A Revenue Loss & Sustainability Fund will: a.)Support providers who are essential to FLPPS success, but may be at risk for financial losses and have exhausted all other resource options; and b.)Make up for financial losses from unforeseen levels of utilization. During later years of DSRIP these funds may be re-allocated into other funding streams such as provider performance payments. 5) If FLPPS receives bonus funds from the state based on performance, those will be distributed to the providers contributing to that performance.

Within the Partner Share of Funds, 85% will be distributed in a way that mimics how FLPPS itself is funded. Providers will be distributed funds based on the number of lives they touch, the complexity of the projects they participate in, and their measurable success under those projects. The formula is multiplicative so the larger the number of lives impacted, the more transformative the projects, and the better their relative performance, the higher their share of funds. It also ensures that providers who do not meet project metrics are not rewarded. 10% of the performance funds will be distributed to partners based on their engagement in the FLPPS planning and governance functions, and 5% will be distributed to CBOs who do not have attributed lives but provide value-add services.

The funds flow plan supports the goals of FLPPS developed by its governance structure, including its Board of Directors (BoD), and many committees that provide representation across the care continuum, across the 13-county region that it services, and across the many functions required to support FLPPS as an entity. Those goals, consistent with the DSRIP program goals, are to transform the delivery system by selecting and participating in DSRIP projects deemed most appropriate for its communities. For FLPPS to achieve the goals

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and metrics of each project, it must reward its providers based on their support and performance in achieving goals and metrics, relative to the size of the overall population that they impact.

The goals of the funds flow plan are threefold: 1) to allow for the creation of FLPPS as an entity able to provide the oversight and project management necessary to meet the goals of the DSRIP projects, 2) to prepare the FLPPS to take on value-based payment methodologies in the future, and 3) to incentivize and reward providers in a way consistent with them helping FLPPS achieve the goals of the selected projects. The finance committee, coordinating with the clinical committee and the executive steering committee, will annually review the results of the FLPPS providers related to DSRIP implementation and assess the impact funds flow has had on this transformative process. Recommendations will be made to the BoD for any necessary changes to the funds flow model.

The FLPPS funds flow model empowers its providers to develop business plans that drive sustainable returns on investments. Because implementation costs and revenue loss are triggered by performance, providers become accountable for making investments in DSRIP project implementation that will lead to high performance.

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	15%
2	Revenue Loss	10%
3	Internal PPS Provider Bonus Payments	0%
4	Contingency Fund Needs such as non-covered services, high costs for niche populations, need for specific population health expertise, termination of state funding streams, and other unforeseen levels of utilization	10%
5	Partner Share of Funds *Majority of funds would flow to providers and partners who are engaged in the work that produces the desired transformation results Further split: *85% based on attributed lives x complexity of chosen projects x performance on project metrics (consistent with distribution met	65%
	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

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to develop a work plan to outline the steps and timeframes in which these milestones will be achieved.

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

☑ Please click here to acknowledge the milestones information above.

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SECTION 9 – FINANCIAL SUSTAINABILITY PLAN:

Section 9.0 – Financial Sustainability Plan:

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

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

Scoring Process:

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

Section 9.1 – Assessment of PPS Financial Landscape:

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

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

As part of its work to identify and include providers in its network, FLPPS created a survey tool, the Request for Qualifications (RFQ), which asked interested provider respondents to provide organizational, IT, and financial data for their organizations. Included in the financial viability section required of all providers (except those small practices with four or fewer providers) was a request for income statement, balance sheet, financial ratios, grant, and utilization data for 2013 and 2014 YTD, and questions asking the providers to indicate how they anticipated DSRIP and other reforms would impact their organizations. The providers were also asked to provide 2013 audited financial statements where applicable.

The FLPPS Operations Finance Committee then adopted a scoring process for evaluating provider financial viability, as part of an overall network refinement tool. The financial section of the network refinement tool broke providers into scoring buckets based upon the type of provider (i.e. SNFs, hospitals, PCPs, community-based organizations, etc.) and then assessed them relative to each other on categories including days cash on hand, operating margin, current ratio, and percent of revenue from grants. The bottom 25% were then identified for further and more detailed assessment based on their provider types.

The Finance Committee reviewed the list of 54 providers who fell into the bottom 25% with the Operations Clinical Committee and determined that these providers were either not considered financially fragile or were considered fragile but would likely be important partners in successful implementation of the DSRIP projects, particularly in underserved rural areas. The Finance Committee determined

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that the revenue loss and sustainability portion of the funds flow would be adequate to backstop financial risk for these providers, should it arise.

***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.

At a high-level, there are three main DSRIP impacts: the impact of reducing existing volumes on certain providers (in particular inpatient admissions, emergency room visits, nursing home admissions), the cost of implementing the DSRIP projects themselves, and the termination of various Medicaid funding programs such as IAAF that have sustained fragile providers. In addition, most of the community-based organizations have very little cash on hand to fund expansion of critical services that will be required for success with DSRIP project implementation.

With the stated objective of reducing 25% of preventable inpatient and emergency room visits, there will be decreases in traditional hospital volumes. The extent of the impact on a particular provider will vary. First, it will vary based upon how many of those preventable visits they currently have at their facilities, and how the changes focused on the Medicaid program will also impact the non-Medicaid volumes at their facilities; any reduction in volumes will not be limited to just the Medicaid population. Second, it will vary based upon how flexible their current business model is. Larger hospitals may have greater ability to reduce staffing levels as volumes change, but smaller providers may run into obstacles such as minimum required staffing that make it difficult to reduce direct costs as volumes fall. Most of the cost savings, aside from the direct cost of supplies that is easier to reduce, will come from labor and will result in either job retraining costs so affected employees may transition to other ambulatory focused positions, or severance costs. The impact on non-hospital organizations that expand volume and/or scope of services will depend on provider category or type, population served under the business model, and the type of service line expansion and/or scope change.

The cost of implementing the DSRIP projects will have a financial impact on all providers. The projects all require some investment, whether it is capital investments, repurposing of existing infrastructure, IT systems, or operating expenses in the form of adding new providers and staff, retraining and redeployment of existing staff, and/or contracting with vendors. The time delay inherent in the DSRIP program, with award dollars not coming for months after a performance period, particularly in the out years, will put pressure on available cash at providers and potentially on operating margins if performance metrics are not met. The availability of capital funding under the Capital Restructuring Financing Program could provide some relief to providers, but it is likely those funds will require at least a 1-to-1 match from the provider.

Both of these impacts can be especially acute for those providers deemed financially fragile. FLPPS will ensure support is available to financially fragile providers essential to the success of DSRIP projects and IDS transformation through the revenue loss and sustainability funds bucket. This funding pool is available at the discretion of the Board of Directors and upon recommendation by the Finance Committee, to support providers in the event of unforeseen financial events. During later years of DSRIP these funds may be reallocated into other funding streams such as provider performance payments.

Section 9.2 – Path to PPS Financial Sustainability:

Description:

The PPS must develop a strategic plan to achieve financial sustainability, so as to ensure all Medicaid members attributed to the PPS have access to the full ranges of necessary services. In the narrative, please address the following:

***Path 1:**

Describe the plan the PPS has or will develop, outlining the PPS' path to financial sustainability and citing any known financial restructuring efforts that will require completion.

FLPPS will develop a Financial Sustainability Plan (FSP) as part of the budgeting process that will address the financial sustainability of the PPS and that will ensure that all Medicaid members in its 13-county region have access to the full range of necessary services. The FSP will be developed under the oversight of the Finance Committee and will be presented to the Board of Directors for approval by March 1, 2015.

In order for the PPS to fulfill its role of ensuring access for all Medicaid members, it must first ensure that it can sustain itself. FLPPS must

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be able to obtain the funds necessary for operations. To this point, the FSP will define specific financial and operational metrics that will allow it to track its success against the DSRIP project goals. The FSP will allow for identification of potential performance issues within its provider network. Actual performance will be compared to budgeted performance at regular intervals and a process to address issues will be outlined.

FLPPS will also have a process for regularly monitoring the financial health of PPS providers and an outline of a process for how FLPPS will address issues of providers, including, but not limited to, access to FLPPS Revenue Loss and Sustainability Fund. At this time, it is known that the FLPPS will need to address potential restructuring of three facilities within its network who have accepted funding via the Interim Access Assurance Fund (IAAF): St James Mercy Hospital, Orleans Community Health, and Wyoming County Community Health System. The Finance Committee will work with each to create a plan that will be accepted by the Finance Committee and the Board of Directors prior to March 1, 2015. There are financial restructuring plans underway related to the three IAAF hospitals that include assessment and potential repurposing from acute care to ambulatory care and other services to further support the goals of DSRIP. Some IAAF recipients are further along in planning their next steps than others.

In addition, FLPPS is developing plans for continuous improvement and monitoring programs for all providers. The plan will include measures to address any providers that encounter financial sustainability issues that put DSRIP projects and care for Medicaid members at risk. In the most serious situations, providers will be removed from the network.

***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.

In addition to the FSP, the FLPPS performance improvement dashboard system will monitor the financial sustainability of each provider, particularly safety net providers. The dashboard will utilize a process similar to that used in initially establishing the PPS network, requiring financial statement and ratio data. If providers are found to be trending towards financial distress, a Distressed Provider Plan (DPP) will be developed and managed by the FLPPS Project Management Office with oversight from the Finance Committee.
Some providers will require short-term financial support due to a variety of factors such as:
-Financial shortfalls as a result of reduced utilization of expensive acute care and long term care services
-Termination of state funding streams, and/or
-The addition of non-covered services.
The Finance Committee will consider providing financial support from the Contingency Fund on a case-by-case basis for the aforementioned providers. For those providers who require a DPP and/or financial support from the Revenue Loss and Sustainability fund, technical support and closer financial operational and/or clinical oversight, as needed, will be provided by the FLPPS PMO

***Path 3:**

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

FLPPS will create a population health management infrastructure to move from volume- to value-based reimbursement methodologies. FLPPS also will engage Medicaid MCOs early in the process to ensure that programs, projects and processes, put in place over the 5 years, result in a financially sustainable organization that delivers the value that payors seek and that the patient population needs. The goal is to sustain and improve upon the gains of the 5 years, as an organization able to accept value-based reimbursement methodologies into the future.

FLPPS has a draft plan for the development of core systems, processes and services to ensure success of the DSRIP projects and overall transformation of the PPS into an IDS. This includes a data warehouse, hosted EHR, disease registry, transportation and care navigation services. This plan will be further developed after a gap analysis to ensure we leverage existing community resources. Though funding will be requested through CRFP, the Finance Committee will coordinate with the HIT, Clinical, Transportation and Housing Workgroups and MCOs to develop business plans for these services to ensure long-term financial sustainability.

Section 9.3 – Strategy to Pursue and Implement Payment Transformation to Support Financial Sustainability:

Description:

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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.

The DSRIP program represents a unique opportunity to invest in the population health capabilities of the PPS and its partners, which can result in a reduction in the cost of care for the Medicaid population while increasing quality outcomes and patient experience. However, DSRIP funding is limited in terms of amount per year, the duration for which it is available, and the ability of FLPPS to work with Medicaid MCOs to develop value-based reimbursement methodologies, both during the five years and after, that will result in additional dollars available to fund incremental improvements in population health capabilities and further the move away from fee-for-service. To this end, FLPPS plans to engage with the Medicaid MCOs in the region, to discuss current FLPPS project plans, given their experience with the population, and to discuss how partnering on value-based reimbursement methodologies might further the alignment of the organizations. What those methodologies look like may be different by MCO and by year. It is anticipated that they may start simpler with arrangements like shared savings and move towards more complex and shared risk arrangements like capitation, as FLPPS develops its capabilities and financial ability to take on risk.

***Strategy 2:**

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

As mentioned previously, DSRIP funding is limited, both in terms of amount and duration. Payment transformation creates a second source of potential income that will allow FLPPS to further invest in the Integrated Delivery System (IDS) that DSRIP is creating. By ensuring sufficient funds, the IDS will provide additional resources for FLPPS to be able to ensure that financially fragile safety net providers remain, and that the Medicaid population has access to the necessary services. The move to value-based reimbursement methodologies across this large of a population, with its unique needs and requirements, is a substantial lift, both operationally and financially for the PPS providers. The FLPPS has selected projects that have the ability to reduce preventable utilization of expensive acute care and other institutional services by 25% and meet the DSRIP projects goals, but there are other projects and opportunities still to be mined, for which the DSRIP funding alone cannot cover the cost to implement. This will encourage transformation that will include retraining and redeployment of the workforce and re-purposing of some existing acute care and nursing home facilities, which will lead to a more sustainable long-term model of care. FLPPS Finance Committee is in the process of designing DSRIP value-based contracts with payment models tied to provider performance metrics, attribution, and complexity of projects. At the same time, FLPPS is preparing to engage in conversations with the MCOs to develop plans for long-term payment redesign via value-based payment contracts and other appropriate methodologies. Through alignment with the DOH and MCOs, and the development of value-based reimbursement methodologies that allow the state, MCOs and FLPPS providers to share in the savings, there are further improvements in cost and quality of care to be had with the future state IDS.

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.

The co-lead organizations of the FLPPS have significant experience in leveraging technical and programmatic resources to improve population health. Both co-leads have commercial ACO-like contracts; RRHS has been recognized by the FTCA since 2007 as an IDN and has a Medicare Shared Savings ACO. Both are recognized as Level 3 Patient Centered Medical Home (PCMH) across their primary care networks, have disease registries to identify and track high-risk patients, embraced team-based care and are actively using care managers to support patients in self-care management. They have been involved in the DOH's Hospital Medical Home Demonstration waiver program, which has assisted with PCMH transformation of residency clinics, coordination of care and inpatient safety efforts for Medicaid beneficiaries, and leveraged HIT for population health management. The co-leads worked collaboratively with Monroe County Public Health and the Center for Community Heath to develop a single Community Service Plan (CSP) involving multiple providers and agencies.

In order to improve population health at the level required; the co-leads recognize they must leverage skills and experience within the FLPSS partnership. Key partners include: 1) The S2AY Rural Health Network, a collaboration of Directors of Public Health from across the Finger Lakes and Southeast NOCNs who work together on a common set of population health initiatives, creating economies of scale to achieve Prevention Agenda goals; 2) The Finger Lakes Health Systems Agency, a regional health planning organization that will be the coordinator of the region's Population Health Improvement Program (PHIP); 3) Community-based organizations, which act as contact points where the PPS target population gathers; and 4) network partners, including rural health networks, hospitals, FQHCs, SNFs and other providers, who have implemented best-practices paradigms and will help with training/roll out of PCMH, INTERACT, IMPACT and Patient Portals.

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.

FLPPS' ability to effectively transform the workforce is one of the most critical factors in changing the way the PPS provides care. As such, the PPS will contract with a workforce strategy vendor who can assist the organization in planning and implementing a comprehensive, large-scale workforce strategy that is responsive to existing resources and identified needs throughout the PPS region.

The FLPPS Workforce Operations Workgroup is finalizing a Request for Applications to evaluate vendors' experience with:
*Strategies in frontline worker engagement when designing new training programs;
*Creative compensation and benefits strategies that facilitate job redesign necessary for a changing healthcare workforce;
*Outplacement strategies and services including individual career planning and resume development;
*Developing career ladder growth and redeployment training programs in tandem with higher education institutions that are equipped to lead programmatic initiatives designed to meet the educational needs of the workforce;
*Building diverse health workforce pipelines;
*Integration with multiple types of academic institutions offering degree and certificate programs;
*Working with individuals making career-changing transitions into the healthcare workforce;

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*Comprehensive health workforce planning with proven success in rural areas; and
*Large-scale projects.
The Workgroup has identified potential vendors that include (but are not limited to) KPMG, Towers Watson, AMS (Applied Management Systems), Huron, Lee Hecht Harrison, AMN Healthcare and Lewin Group.
Next steps:
1. Finalize a Request for Applications (RFA) based on evaluation criteria
2. Release RFA for PPS stakeholder comment
3. Receive comments and update RFA
4. Release RFA to vendors for completion
5. Convene a vendor evaluation team to assess submitted RFAs and make recommendations
6. Narrow list of potential vendors for Workgroup vote
7. Workgroup vote to select vendor(s)

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

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

DSRIP PPS Organizational Application

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SECTION 11 – ATTESTATION:

Attestation:

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

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

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

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

☑ ***I hereby attest as the Lead Representative of this PPS Finger Lakes PPS that all information provided on this Project Plan Applicant is true and accurate to the best of my knowledge.***

Primary Lead Provider Name: ROCHESTER GENERAL HOSPITAL
Secondary Lead Provider Name: UNITY HOSPITAL ROCHESTER

Lead Representative:	Carol Fisher
Submission Date:	12/22/2014 09:45 AM

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