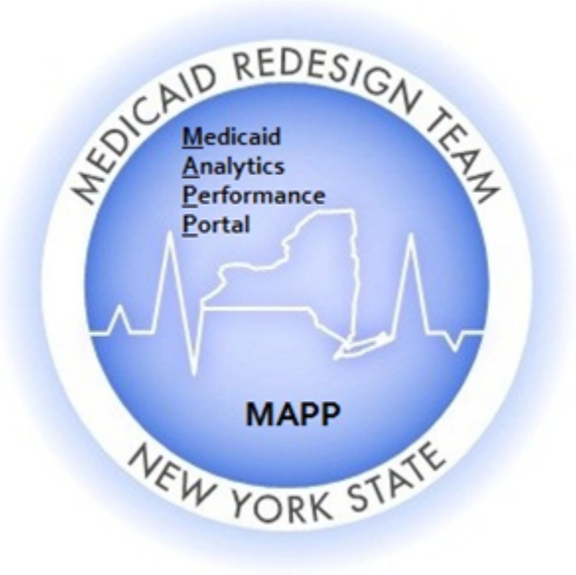
New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP PPS Organizational Application



Mohawk Valley PPS (Bassett)

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

DSRIP PPS Organizational Application

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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: **22_SEC000_Leatherstocking Collaborative Health Partners dsrip_pps_lead_financial_stability_test_application_COMPLETE.pdf**

Description of File

Combined file with the stress test along with financials.

File Uploaded By: swathirg
File Uploaded On: 12/20/2014 12:41 PM

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

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

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

Last Updated By: swathirg
Last Updated On: 12/21/2014 03:09 PM

Certified By: bertinem
Certified On: 12/21/2014 03:21 PM
Lead Representative: Bertine Mckenna

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	Create an integrated delivery system	Through the implementation of Project 2.a.ii PCMH, the PPS will ensure that all participating primary care providers meet NCQA 2014 Level 3 PCMH recognition by the end of Demonstration Year 3. Under the proposed project, the PPS will ensure that all PPS safety net providers are actively sharing EMR systems with local health information exchange/RHIO/SHIN-NY and that all participating clinical partners share health information.
2	Implement care coordination and transition care programs	Through the implementation of Project 2.b.vii (Skilled Nursing/LTC) and Project 2.b.viii (Hospital Home Care), the PPS will: 1) focus on evidence-based strategies to reduce patient transfers to acute care facilities due to mismanagement of acute changes in their condition, and 2) improve transitional care for patients with chronic conditions by employing a Rapid Response Team to facilitate patient discharge to home and assure needed home care services are in place. Both projects will work together to improve patient management and care across settings.
3	To connect settings and expand access to community-based care	Through the implementation of Project 2.c.i (Navigation Program) and Project 2.d.i (Patient Activation), the PPS will: 1) deploy community health navigators to improve health literacy and to engage patients with community health care services, and 2) find service area residents who are not utilizing health care services and engage them in the PPS to improve their health outcomes. These projects will work together to improve the appropriate utilization of PPS services over the next five years.
4	To implement clinical improvement across disease states and disease management methods	Through the implementation of Project 3.a.i (Behavioral Health), Project 3.a.iv (Ambulatory Detox), Project 3.d.iii (Evidence Based Asthma Management), and Project 3.g.i (Palliative Care), the PPS will take a strategic approach to improve clinical outcomes in four key areas. This will be accomplished by: 1) integrating behavioral health and primary care (a goal shared by multiple DSRIP projects); 2) enhancing patient access to community-based withdrawal management services with linkages to care management; 3) increase asthma management for child and adult patients diagnosed with asthma, or patients with asthma symptoms; and 4) assemble a palliative care support team that will lead the development of clinical and consultation to primary care providers, enabling patients to more effectively manage their end of life care and prevent unnecessary hospitalizations.
5	To promote mental health and prevent substance abuse chronic diseases	Through the implementation of Project 4.a.iii (Strengthen MH and SA Infrastructure) and Project 4.b.i (Smoking Cessation), the PPS will: 1) expand the existing use of Screening Brief Intervention Referral to

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#	Goal	Reason For Goal
		Treatment (SBIRT) across all participating primary care and behavioral health sites, by providing continuing medical education training to an expanded population of health care providers in the PPS; and 2) take a population-based approach to promote smoking cessation through evidenced-based programming, health education, and advocacy; and reach all smokers, including people with disabilities, low SES and mental health issues, during their primary care visits. EMR capabilities will be expanded to bolster interconnectivity and facilitate coordinated care of substance abuse/smoking cessation and MEB disorders.

***Formulation:**

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

PLEASE NOTE: UPON A VOTE OF PARTNERS, THE PPS NAME IS NOW LEATHERSTOCKING COLLABORATIVE HEALTH PARTNERS (LCHP). LCHP was established to represent the geographic, demographic, and service delivery needs of its residents. The PPS includes consumers and providers across the care continuum. LCHP chose the collaborative governance model to reflect the diversity of partners in its geographical area and to foster engagement among said partners. To address equitability of access and service, LCHP will establish a consumer subcommittee to advocate for the target population. Transparency and dialogue among partners and leadership will characterize the decision making process for the organization. Communication to the community with be accomplished through varied channels, including a publicly-accessible website, open meetings and town halls.

AS A MATTER OF EXPLANATION, THE CNA PROVIDES DATA FOR THE STRATEGIC SEVEN-COUNTY AREA SERVED BY BASSETT. THE RECENT PERFORMANCE ATTRIBUTION REMOVED LCHP PARTICIPATION IN TWO COUNTIES (ONEIDA/CHENANGO). LCHP WILL CONTINUE TO SERVE PATIENTS IN THESE COUNTIES AND PARTNER WITH ADJACENT PPS'. PLEASE NOTE THIS UPON REVIEW OF CNA AND PROJECT DATA.

***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.

LCHP will transform its service from a dispersed constellation of unconnected providers into an integrated delivery system providing high-quality, responsive, appropriate and cost-effective care to its residents. Care will be provided using a population-based health management approach, made possible by an interconnected and integrated data-sharing platform. Unnecessary care utilization will be avoided by LCHP's increased capacity to provide comprehensive primary care and integrated behavioral health services. Coordinated care will be conducted by a network of culturally competent community health navigators, representing the communities they serve. Working collaboratively, partners will reduce barriers, as cited in the CNA, including insufficient transportation services, low health literacy, and disengaged patients. LCHP will undergo a transformation by becoming a financially sustainable, risk-bearing entity operating under a value-based payment system that will be characterized by cost effectiveness, accessibility, affordability, high quality, and patient satisfaction.

***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

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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	Revenue Sharing Waiver - 10 NYCRR 600.9(c)	The PPS is seeking a regulatory waiver to permit the lead agency, The Mary Imogene Bassett Hospital doing business as Bassett Medical Center, to distribute DSRIP funds to its PPS Partners in accordance with its funds flow model. The waiver permitting the distribution of DSRIP funds by the lead agency would apply to all projects identified in this application for which funds will be distributed to non-established PPS Partners. The waiver is requested in order to permit the lead agency to distribute DSRIP funds to its non-established PPS Partners. Such a waiver would facilitate implementation of the projects identified in this application. Without a waiver of this regulation, DSRIP funds could not flow to the non-established PPS Partners to support implementation of the projects herein. No alternatives exist other than a waiver to this regulatory prohibition preventing the lead agency from sharing its total gross income or net revenue derived from DSRIP funds with non-established PPS Partners. The cited regulatory provision does not pertain to patient safety and the granting of such a waiver would not risk patient safety but, in fact, allow the funding of the DSRIP projects, the intended goal of which is to transform the participating providers into a highly efficient Integrated Delivery System by the end of the DSRIP Program.
2	Geographic Service Area Waivers- 10 NYCRR Part 760	The PPS is seeking regulatory waivers for Certified Home Health Agencies (CHHA) listed below to operate outside of their permitted geographic service areas 1) At Home Care, Inc. (AHC) Certificate of Authorization (COA) No. 3824601 Fac ID # 3912 Regulatory waiver for AHC to operate as a CHHA in Oneida and Madison Counties 2) Community Health Center of St. Mary's Healthcare and Nathan Littauer Hospital (CHC) COA No. 1758601 Fac ID # 3298 The PPS is requesting a waiver for CHC to operate a CHHA in Oneida County HCR COA #s 2627601 and 127602 Facility ID #s 1877 & 5521 Regulatory waiver for HCR to operate as a CHHA in Oneida, Herkimer and Chenango Counties This waiver is requested for the following projects 2.b.viii., 3.d.iii., & 3.g.i. Approval will result in the CHHAs as PPS Partners to serve the home health needs of the PPS service area. Ineffective management and care coordination of medically complex patients is a major driver of avoidable hospital use. CHHAs are of significant importance in meeting the needs of the community and cutting reducing costs by preventing avoidable admissions. Follow-up care and coordination after hospital discharge-the cornerstone services provided by a CHHA-are key weapons in meeting the program's goals. The PPS has CHHA partners that currently do not serve the entire PPS geographic area. The CHHAs have the capacity to expand

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#	Regulatory Relief(RR)	RR Response
		their geographic service areas into the identified counties There are no alternatives to compliance with the regulatory standard. The granting of requested regulatory relief does not adversely impact patient safety. Approval will positively impact patient safety and result in promoting efficiency, cost savings and quality improvement.
3	Integration of Primary Care and Behavioral Health Services Waiver - MHL Articles 31 and 32	The PPS is seeking a waiver from the regulations under MHL Articles 31 and 32 to allow co-location of primary care services at behavioral health sites under a single license or certification issued under the PHL or MHL. Project this waiver is needed for: 3.a.i – Integration of Primary Care & Behavioral Health Services • Integration of primary care services into established behavioral health sites such as clinics and Crisis Centers. • Co-locate primary care services at behavioral health sites. • Conduct preventive care screenings, including behavioral health screenings (PHQ-9, SBIRT) implemented for all patients to identify unmet needs. The intent of project 3.a.iv is to co-locate primary care practitioners in an OMH and/or OASAS licensed or certified site to conduct preventive care screenings to identify unmet needs. The inability to co-locate services without a waiver will preclude the project from being implemented. There are no other known alternatives. • Every primary care provider participating in this project will be fully credentialed in the provision of primary care services to the appropriate population. • The primary care provider will abide by the regulations as set forth by OMH and OASAS. • All staff will be appropriately trained on policies and procedures relating to the OMH and/or OASAS regulations with regard to HIPPA, patient confidentiality and patient safety. • Mandatory annual education will be required by all staff.
4	Sharing of Space by Primary Care Providers and Behavioral Health Service Providers-10 NYCRR Part 401	The project this waiver is needed for is 3.a.iv Development of Withdrawal Management (e.g., ambulatory detoxification, ancillary withdrawal services) Capabilities and Appropriate Enhanced Abstinence Services within Community-Based Addiction Treatment Programs • Identify and link to providers approved for outpatient medication management of opioid addiction who agree to provide continued maintenance therapy and collaborate with the treatment program and care manager. • These patients can be monitored in an outpatient program until stability is assured and, then, rapidly integrated into a collocated outpatient SUD program with PCP integrated team. As the project is developed, our plan is to coordinate with other PPS to provide addiction services via telemedicine until a board-certified addictionologist can be recruited. It is essential that our primary care providers, with whom our patients have an established relationship, are able to intervene early in the process to initiate treatment. There are no alternatives.

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#	Regulatory Relief(RR)	RR Response
		• Every physician will be trained in the use of buprenorphine for the treatment of opioid addiction. Said training will review legislation regarding office-based opioid-addiction treatment, pharmacology, safety and effectiveness, patient assessment and selection, clinical management, special treatment populations, dosing, urine testing, and patient confidentiality. The training will meet the 8-hour training requirement specified in the Drug Addiction Treatment Act of 2000 for physicians to qualify for prescribing and dispensing buprenorphine in their offices for the treatment of opioid dependence. • Every primary care requesting such privileges will be required to submit the request to the chief of service. Upon approval, the request will be reviewed by the credentials committee and the medical executive committee for final review and approval. • Every primary care provider participating in this project will be fully credentialed in the provision of services to this population. Re-credentialing will occur routinely to assess the need for this continued privilege. • Every physician/provider with said privileges will adhere to medication safety policies and reporting of adverse events with regard to said treatment. • All staff will be appropriately trained on policies and procedures with regard to HIPAA, patient confidentiality, and patient safety. • Mandatory annual education will be required by all staff.

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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.

Leatherstocking Collaborative Health Partner (LCHP) will provide stewardship and oversight to the chosen projects and their associated clinical, financial, IT/data analytics, and compliance functions. The ultimate goal of LCHP is to meet the pressing community needs elucidated by the community needs assessment informing this application. Based on a review of its governance needs, the Project Advisory Committee (PAC) selected the Collaborative Contracting model as the LCHP governance structure. In choosing this model, the PAC carefully considered a number of factors including the need to accommodate future growth and development, address the challenges inherent in a rural location, and foster strong local engagement among the participating sites. The Collaborative Contracting model was chosen because it will accommodate the evolution of the governance structure from planning through integrated service.

The governance structure will ensure balanced representation of the partner agencies as illustrated in the attached organizational chart. The Mary Imogene Bassett Hospital d/b/a Bassett Medical Center ("Bassett") and its LCHP Partners will enter into written operating agreements, which will identify Bassett as the lead agency, will establish the LCHP governance structure, including standing committees,

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and will authorize Bassett to enter into written agreements with other LCHP partners. The LCHP governance structure will be governed by written articles of governance and will generally conform to that prescribed for a not-for-profit corporation under New York's Not-For-Profit Corporation Law with membership in a governing body known as the Executive Governance Body (EGB), and various standing committees, including Finance, Clinical Performance, IT/ Data Analytics, and Compliance. Bassett has a strong track record of monitoring and managing contracts having used a similar model to connect legacy agencies in its Medicaid Health Home. Bassett will contract with the New York State Department of Health (NYSDOH) and each LCHP partner. It is anticipated that, under the contract with NYSDOH, Bassett will maintain significant financial responsibility on behalf of the LCHP and will maintain final decision making authority through the proposed Executive Governance Body and all standing committees. The LCHP operations team will be supported by a project management office and will work collaboratively with partners to achieve LCHP goals. Bassett will manage the implementation of contractual arrangements in this governance structure. Foremost on the timeline is the need to establish the Executive Governance Body, reorient the PAC to a true advisory role and eliminate the Governance Subcommittee. These elements will be in place by January 15, 2015.

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: **22_SEC021_Mohawk Valley PPS AKA Leatherstocking Collaborative Health Partners_ Section 2.xlsx.pdf**

Description of File

Section 2: Organizational Chart in implementation phase

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***Structure 2:**

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

All partners will have a proportionate role in the governance process. The project teams will have adequate respresentation on the Clinical Performance, Finance, IT/Data Analytics and Compliance Committees. These standing committees are established and will be fully functional by April 1, 2015. They will be responsible for meeting specific performance measures and will be accountable to the Executive Governance Body (EGB). All standing committees will be staffed by representatives from the LCHP operations team as its support will be integral to the teams as they strive to meet their performance goals. The Finance Committee will be responsible for recommendations to the EGB regarding funds flow management, including project and transition costs, performance awards, requisite penalties, compensation for revenue losses, and funding of innovative initiatives. The IT/Data Analytics Committee will be responsible for developing the overall data and IT strategies, aligning them with the goals of the LCHP by ensuring interoperability of the LCHP partners. The committee will further coordinate data sharing and storage, standardization, training, allocation of resources and information security and compliance. The Compliance Committee will identify and address issues concerning compliance that may emerge in relation to the LCHP implementation. The compliance program will be in place by April 1, 2015 and will build upon existing processes. Additionally, two other critical components will be established by April 1 under the terms of the operating agreements: a dispute resolution process and a process to manage non-performing partners. Upon approval of the application, the LCHP will fully implement the chosen model, with clarity of roles, responsibilities, and authorities among the LCHP Partners.

***Structure 3:**

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

The Clinical Performance Committee will recommend the clinical quality standards to the Executive Governance Board with a performance improvement philosophy of continuous improvement and zero tolerance for avoidable errors. The committee will oversee the development, dissemination and implementation of standardized, evidence-based clinical pathways and will track, monitor and oversee compliance with standards based on the assessment of outcomes. It will make recommendations for improvement for projects not meeting the established metrics. The committee will be comprised of effective clinical leaders to ensure that these objectives are fulfilled. It is anticipated that the committee will have fifteen to eighteen members, have ample physician representation, and be appropriately chartered. In addition, there

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will be quarterly meetings of project chairs to assure integration, efficiency, and optimization of resources.

***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.

During the implementation phase, the governance structure will evolve as the decisions made in the planning phase are operationalized. The decision-making authority will transfer from the PAC to the newly established Executive Governance Board (EGB) in the first quarter of 2015. This evolution will involve the further development of the standing committees. When fully operational, Bassett will monitor the success of the governance structure annually, corresponding to the semi-annual project reports and integration surveys in which LCHP members will be asked to highlight the specific governance methods that have produced the most effective results. Over the implementation phase, it is anticipated that the current competitive model will evolve into more collaborative relationships, as project teams meet their metrics and milestones. This model will afford increased flexibility as the LCHP moves toward a more integrated system over the five year period. The transition to a limited liability corporation has been reviewed and approved by the existing PAC for implementation by the newly formed EGB and Bassett. By the end of the DY0, all contracts will be in place. During the life of the DSRIP program, LCHP will utilize value-based contracting with all payers to provide an approach to total population health management through an integrated delivery system.

Section 2.2 - Governing Processes:

Description:

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

***Process 1:**

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

The Executive Governance Body (EGB) will be comprised of 11 members: six from Bassett (lead agency) and five from LCHP partners. Bassett will maintain a majority, with six members representing the "swim lanes" with consideration given to appropriate graphical representation. The partners will select five members also representing the swim lanes, paying particular attention to those for which Bassett cannot offer representation.

EGB members are responsible for attending and actively participating in meetings either in person or via conference call, offering professional expertise during discussion and conducting presentations as requested. They are expected to adopt the perspective of the LCHP in its entirety and to assume a stewardship role.

***Process 2:**

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

During the planning phase of the Leatherstocking Collaborative Health Partnership (LCHP) project application, the Project Advisory Committee (PAC) was the governing body for LCHP. This body was formed through a selection of members from partnering organizations representing the swim lanes that determined the attribution of lives to LCHP. Members include representatives from labor unions, community-based organizations, behavioral and mental health agencies, providers for people with the developmental disabilities and other key stakeholders.

The members of PAC have extensive experience in working with the Medicaid program and its patients and understand the value of working collaboratively. The process through which the PAC recommended the design of the EGB emerged from discussions that occurred between the Governance Subcommittee and legal counsel. The Governance Subcommittee reviewed a number of models, carefully weighed the benefits of each, and brought recommendations to the PAC. Upon review and discussion, the PAC unanimously approved the recommendations of the Governance Subcommittee in determining the structure and representation of the newly formed EGB. The structure of the EGB was established with reference to the tenets of the collaborative governance model. The PAC determined that the EGB will be composed of six members appointed by Bassett and five members to be selected from the partner pool. The EGB will be selected with adequate partner representation using the "swim lane" methodology. Bassett will select members from emergency services, acute care, long-term care, primary care and Medicaid Health Home. Partners will be chosen with consideration for geographic

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representation and the "swim lanes" not otherwise represented by Bassett. LCHP leadership will consult with the non-lead-agency co–chair of the existing Governance Subcommittee to develop a process for selecting the remaining five members of the EGB.

***Process 3:**

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

The membership of the Executive Governance Body (EGB) reflects geography, community-based status, administrative and clinical function, demographics, position along the care continuum and "swim lane" categories as outlined in the attribution process. Each partner has experience working with the Medicaid program and the population receiving benefits. Ranked 48th in the nation for integrated health networks (IMS Health, 2012), The Bassett Healthcare Network is the primary integrated network delivery system in Central New York, encompassing a Medicaid Health Home program, six hospitals, 37 community health centers, 19 school based health centers, two nursing homes, an array of behavioral health services, a home care program and a durable medical equipment company. This coupled with the diversity of the partner composition and the process for member selection yields an EGB membership reflective of partner interests.

***Process 4:**

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

To date, partnering organizations have been included in the Governance Subcommittee and in each project committee according to their interests and specific roles. LCHP has entered into partnerships with numerous community-based organizations representing the diverse groups in its service area. LCHP has contracted with these partner organizations to transform the Medicaid service delivery system on a project-specific basis. Performance standards will be integrated into formal contracts and rapid cycle evaluations. Some LCHP partners, though not directly involved in specific projects, will serve in a consulting capacity as appropriate (e.g., the Catskill Hudson Area AHEC will serve on this PCMH project subcommittee).

***Process 5:**

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

The Executive Governance Body's (EGB) decision making/voting process will adhere to New York's Not-For-Profit Corporation Law (NFPCL), which states that any member in good standing, otherwise eligible to vote, is entitled to vote at any meeting of members. There are 11 members on the EGB, each having one vote. As approved by the PAC, actions will be authorized by a majority or supermajority of the votes cast at a meeting of voting members. A quorum will consist of a majority of the members. An action will be taken if the affirmative votes cast in its favor are at least equal to the quorum. Robert's Rules of Order will be followed to implement the voting process. The team will engage in group voting; members will cast votes with an "aye" or a "no." Per NFPCL, any board members not physically present at a meeting of the board or a committee may participate by means of a conference telephone or by electronic video screen communication. Voting outcomes will be recorded in the minutes. Removal of members will be by supermajority vote. Per NFPCL, regular meetings of the board may be held without notice. Special meetings of the board can be held upon notice to the members. The EGB will adhere to NFPCL with respect to notices, waivers, proxies and written consent of the EBG.

***Process 6:**

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

Executive Governance Body (EGB) members with unresolved conflicts will be able to approach the Chair or the Vice Chair, who will meet with them separately from the EGB to resolve the issue. If necessary, the issue will be brought to the EGB for discussion and resolution. This will be further clarified with each partner in the operating agreements.

***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.

Meetings of the Executive Goverance Bbody (EGB) will be open. Meeting schedules, agendas and minutes will be posted on the publically-accessible LCHP website. Actionable items will be detailed in the minutes and will include attendees' names. Special closed meetings may be held to discuss confidential issues (personnel, etc.) LCHP will have an active stakeholder engagement process,

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including surveys of project teams and an email address on the LCHP website where stakeholders can provide feedback. LCHP will host town hall meetings that will be announced on the LCHP website and in the community. The Project Advisory Committee will oversee these activities and share results and feedback with the EGB and 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.

A Consumer's Subcommittee of the Collaborative Learning Committee will be established to include community members, Medicaid recipients, and the uninsured. Subcommittee members will provide feedback on patient engagement, recruitment, outreach and dissemination and utilization of community-based resources making specific reference to cost, quality and patient experience. Further, LCHP leadership will provide information to the Consumer Subcommittee regarding project development, LCHP development, and other items of consumer interest. The Consumer's Subcommittee will meet on a regularly-scheduled basis and act as an advocate for patients, voicing their experiences and those of other stakeholders. Further, there will be an established patient representative service, available patient surveys in health facilities, CAHPS surveys and information from project team work which will offer additional sources of feedback.

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.

LCHP has been led by a 22-member Project Advisory Committee (PAC). The PAC was formed in April 2014 as a result of initial communications and meetings between the Bassett, project supporters, collaborators, stakeholders, community-based providers and consumers during the initiation of the LCHP planning phase for the emerging PPS. Early in 2014, Bassett engaged more than 50 partnering organizations and proposed an alternative PAC structure based upon the large number of expected members. PAC membership included one member from organizations with greater than 50 employees. In addition, PAC representation included a labor union, a smaller health care organization, and a community-based organization. LCHP partners not represented on the PAC were invited serve on the project committees based on their organization's history of excellent service to Medicaid patients and their ability to work collaboratively, with the ultimate goal of providing representation of the care continuum and LCHP service area. As initially constituted, PAC members were leaders and staff from hospitals, nursing homes, assisted living facilities, home health agencies, mental health clinics, community-based organizations as well as providers serving developmentally disabled populations. Their work was a vital part of the formation of the Leatherstocking Collaborative Health Partners LCHP.

***Committee 2:**

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

The purpose of LCHP PAC is to offer guidance, suggestions and recommendations regarding the overall performance and structure of LCHP. The PAC will serve as an initial reference point for new programs and innovative proposals, as well as strategic considerations. The committee will provide guidance on working relationships with external organizations, including the New York State Department of Health, county health departments, and the Office of Mental Hygiene. The PAC will make recommendations regarding the extension of invitations to external organizations in joining LCHP. Additional responsibilities will include communicating feedback regarding performance, access, cost, affordability, quality, and the patient experience. PAC members will be expected to communicate recommendations regarding integration and LCHP financial feasibility to the EGB.

***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).

During the planning phase, as the leadership and decision-making body, the PAC formed the Governance Subcommittee, which then developed the recommended LCHP organizational structure for PAC approval. PAC had general oversight of the LCHP projects, including initiating all planning and implementation of the Community Needs Assessment (CNA). The CNA team and Advisory Group had the primary responsibility for conducting the CNA and for reporting the results of interim and final analyses back to the PAC. In addition to

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guiding the planning and completion of the CNA, the PAC played an active role in the qualitative component, participating in forums with stakeholders and engaging them throughout the CNA process, using formal and informal methods to assess the community needs and resources in the region.

***Committee 4:**

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

The new composition of the PAC in the implementation phase will be 21 members to be appointed by the EGB. The PAC will represent the diversity of the LCHP, reflecting demographics, geography, size of partnering organizations, safety-net providers, health occupations, administrative and practitioner categories, behavioral health organizations, community-based organizations, and service-delivery entities. The PAC membership will include community members, at least one of whom will be a Medicaid beneficiary, one non-managerial employee from among the partner organizations and an employee from a unionized partner.

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.

Bassett's Compliance Officer will serve as the designated compliance official. The current compliance officer is the Vice-President of Performance Improvement and Care Coordination at Bassett Medical Center and is a nationally certified professional in patient safety. A member of the HANYS Council on Quality Initiatives and the NYSDOH Patient Safety Committee, this individual has led clinical quality, risk management and patient safety initiatives for 15 years and has spearheaded statewide efforts to reduce hospital readmissions and improve patient safety. She will chair the Compliance Committee with a non-Bassett co-chair. The committee will report directly to the Executive Governance Body (EGB).

***Compliance 2:**

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

LCHP's compliance program will implement processes mirroring those that are in place through Bassett's well-established compliance program, which meets the requirements of 18 NYCRR 521.2 (b). The compliance officer will ensure the continuous monitoring and presence of an anonymous hotline, an intranet webpage, a dedicated e-mail address, and an open-item reporting form. Under the written articles for governance for LCHP, a Compliance Committee will be established to review all compliance issues. The committee will report to the Executive Goverance Board and will include a compliance analyst and subject matter experts from LCHP partner organizations. The compliance analyst will provide internal auditing and objective assurance on governance, risk management, and control processes within LCHP. The Compliance Committee will report on concerns and actions related to the hotline to the EGB. Partner contracts will stipulate the partners' compliance obligations.

***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.

LCHP partners will receive compliance training structured according to the New York State Office of the Medicaid Inspector General's (OMIG) eight required elements of an effective compliance program, including:
1. Written Policies and Procedures (based on Bassett's existing Code of Conduct)
2. Designation of a Compliance Officer
3. Training and Education
4. Communication Lines to the Compliance Officer
5. Disciplinary Policies
6. Identification of Compliance Risk Areas and Non-Compliance

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7. Responding to Compliance Issues
8. Policy of Non-Intimidation and Non-Retaliation

The Compliance Committee will review Bassett's existing compliance training program, which includes the components listed above and meets the requirements of 18 NYCRR 521.2 (b) and will broaden and revise it as appropriate to provide training throughout LCHP.

***Compliance 4:**

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

The Compliance Committee will review Bassett's existing compliance training program, which includes the components listed above and meets the requirements of 18 NYCRR 521.2 (b) and will broaden and revise it as appropriate to provide training throughout LCHP.

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.

In the implemtation phase, the Finance Committee will develop and recommend the flow of funds model including the distribution of funds, process for revenue shifting, and methodology for incentive distribution. The EGB will approve the funds flow model recommended by the Committee prior to distribution of funds. The Finance Committee will oversee the budget process and compile and summarize financial statements for reporting to the Executive Governance Body (EGB). The EGB will monitor revenue, expenses, and outcomes to ensure that funds are being used effectively toward the mission of LCHP. The financial health of LCHP will be measured using standard accounting principles and relevant analytical ratios. For each project, variances will be routinely addressed and shortfalls in revenue will be analyzed. The EGB will evaluate the financial condition of LCHP, weighing the need to expand or contract programs and services with the goal of identifying underperforming organizations early to allow for timely intervention and remediation.

***Organization 2:**

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

Key finance functions will include budgeting, financial planning, and reporting, in addition to establishing and monitoring internal controls and accounting policies. Accounting processes, infrastructure, and software will be developed. Utilizing the Bassett's well-established financial policies and procedures that ensure key functions are separated, processes will be implemented allowing the Bassett's Finance Department to receive and account for LCHP funds, with direct reporting to the LCHP Finance Committee. Variance analysis will be performed for all LCHP projects. Adequate internal controls will be established which will include segregating duties to safeguard resources, implementing procedures for comparing actual outlays to budget forecasts and establishing internal auditing processes. These processes will be subjected to external audit. The Finance committee will implement the funds flow model as approved by the Executive Governance Body.

***Organization 3:**

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

For matters that fall under the aegis of the compliance program, compliance staff will provide auditing and analysis for governance, compliance-related risk management, and control processes for LCHP. Recommendations will be made for improving the governance process, ensuring effective performance management and accountability, communicating risk and control information and coordinating the information flow among auditors and management. Internal audits, conducted by designated finance, privacy/security and information technology staff, will safeguard assets and ensure compliance with laws, regulations, policies, procedures, and contracts. The committee will also recommend and maintain procedures to minimize the risk of fraud. Controls will be reviewed regularly for effectiveness and efficiency. An external auditor will provide audits of financial statements, processes and controls.

***Organization 4:**

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

LCHP will establish and implement a compliance program consistent with NYS Social Services Law 363-d. The program will include a compliance committee, an anonymous hotline, an intranet webpage, a dedicated compliance e-mail address, and an open-item reporting form. Compliance issues emerging from LCHP will be tracked using a database created for this purpose and will be reported to the Executive Goverance Board. All LCHP partners will receive requisite training in accordance with the New York State Office of the Medicaid Inspector General, including written policies and procedures, designation of and communication lines to a compliance officer, training and education, disciplinary policies, identification of risk areas and non-compliance, procedures for responding to compliance issues, and a policy of non-intimidation and non-retaliation.

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.

Performance benchmarks, minimal level of performance, monitoring processes and terms of renewal and removal will be included in the partner operating agreements. LCHP will establish standards and routinely monitor performance through each project's rapid cycle evaluation, which will be based upon established clinical performance metrics. It will also monitor financial performance quarterly against the budget and other established metrics. LCHP will access metrics contained in the Medicaid Data Warehouse. Web-based performance dashboards will provide baseline performance data and data by region. LCHP will collect and incorporate into its monthly performance monitoring qualitative feedback obtained from consumers and the community through the LCHP website, the Consumer Subcommittee, the compliance hotline, town hall meetings, letters and phone calls.

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

LCHP will engage in routine monitoring and review of performance metrics. Once performance issues are identified, LCHP will provide the partner with a written summary of the deficiency. Representatives of the relevant project committee(s), members of the Executive Goverance Board and the partner organization will review the summary in a closed session. LCHP will work with the partner to identify the source(s) of its underperformance, such as staff turnover, population, or provider performance. The intent is to improve the performance of the provider(s). Underperforming partners will be identified and performance improvement measures implemented before removal is considered or recommended.

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

A partner with performance deficiencies will meet with the Executive Governance Body (EGB), after which it will have 30 days to produce a written corrective action plan. The plan will include actions for remediation, due dates by which corrections must be implemented and a plan for regular follow-up reporting to the EGB. The EGB will review the plan and vote on its acceptance in a closed session. It will return a decision to the partner within 14 calendar days of receipt. Every effort will be made by the EGB to assist the partner in devising a plan that will be mutually acceptable to all parties. Once finalized, the final plan will be signed by representatives of the partner and the EGB, and then implemented. The partner may consult with any partner of LCHP during any time in the remediation process. If the performance remains below the minimum standards for 90 days or more or if there is no agreement on a plan of correction, the EGB will vote on whether to allow the partner to revisit the plan or to remove the partner from LCHP. If the vote is for removal, the EGB will confer with Bassett and the Department of Health to submit a recommendation to remove. Removal of a partner is subject to a supermajority vote of the EGB.

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

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Medicaid beneficiaries and their advocates will have a number of channels through which they will be able to provide feedback to the LCHP. This feedback will be considered when making decisions regarding partner renewal or removal. These channels will include a feedback screen on the publically accessible LCHP website and the anonymous compliance hotline (publicized at all sites). Additionally, patient satisfaction surveys will be an integral component of each project's evaluation process. Further, the Consumers Subcommittee and the widely-publicized town hall meetings will provide beneficiaries and the community with public forums for discussion. Finally, all mailings and correspondence will include a telephone number and address that beneficiaries may use to provide feedback directly to LCHP.

***Oversight 5:**

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

Beneficiaries will be notified through multiple channels if a provider is removed from the LCHP. Every effort will be made to obtain and use the beneficiary's preferred method of communication. This information will be posted on the publically available LCHP website, shared with the Consumers Subcommittee and publicized at town hall meetings. The information will also be shared with beneficiaries via newsletters and direct mailings. Finally, removal of partners will be included in the minutes of the EGB, which will also be posted on LCHP website.

Section 2.7 - Domain 1 – Governance Milestones:

Description:

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

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

☑ Please Check here to acknowledge the milestones information above

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SECTION 3 – COMMUNITY NEEDS ASSESSMENT:

Section 3.0 – Community Needs Assessment:

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

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

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

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

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

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

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

This section is broken into the following subsections:

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

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

Scoring Process:

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

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

Section 3.1 – Overview on the Completion of the CNA:

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

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

A community needs assessment (CNA) working group within Bassett Research Institute was formed in August and began identifying potential members of the CNA Subcommittee to provide guidance on the CNA for the 7 counties of the Leatherstocking Collaborative Health Partners (LCHP) - see the statement on inclusion of counties for the CNA in the Formulation section of Executive Summary. A candidate list was compiled from (1) stakeholders with experience leading the 2013 CNAs prepared by health departments and hospitals of LCHP counties for the NYS Department of Health; (2) partners and partnering organizations for the DSRIP application; and (3) nominations by members of other DSRIP committees. 30 individuals were chosen representing all 7 counties and all ten community sectors identified in the IOM Report The Future of the Public's Health in the 21st Century as crucial for assuring conditions for public health. The CNA subcommittee met at the beginning of October to discuss initial findings for DSRIP metrics in the 7 counties, to critique the initial inventory of community resources and assets and to identify gaps in documentation of health concerns and community capacity for health promotion. During October members of the CNA subcommittee worked with the CNA working group to address the aforementioned gaps and the rationale for DSRIP projects under consideration by suggesting additional relevant data (often from their own organizations), by including discussion of the CNA in their organizations' October meetings (the working group participated in 10 such meetings) and by facilitating input of Medicaid beneficiaries and the uninsured through brief, anonymous surveys distributed within their organizations and through support for 3 focus groups. An updated summary of CNA findings and their relationship to proposed DSRIP projects was sent to the CNA subcommittee in mid-November for further input on CNA evidence and recommended linkage of community resources to projects.

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

The DSRIP performance data were an initial source of information, with measures derived from vital statistics, hospital discharge data (SPARCS), the Behavioral Risk Factor Surveillance System (BRFSS), Healthcare Effectiveness Data and Information Set (HEDIS) and the US Census. The Health Data website of the NYS Department of Health was a resource for additional data from the same sources (e.g. drug-related hospitalizations in SPARCS; prevalence of exposure at home to second-hand smoke in BRFSS) and new sources (e.g. Nursing Home Quality Initiative survey findings; the New York Codes, Rules and Regulations projections for residential health care facility bed resources and needs). CNA data also came directly from PPS partners, e.g. cause-specific information from hospitals on potentially preventable readmissions (PPRs); home health summaries compiled by CMS for home health agencies on client characteristics and outcomes; and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures on primary care access, communication and coordination collected and reported to providers by Press Ganey. Additional community-based surveys were the Youth Risk Behavioral Survey (YRBS) for information on adolescents and the Upstate Health and Wellness Survey (UHWS), conducted in 2009-2010 on a random sample of residents in the LCHP region and providing data on 450 adult Medicaid beneficiaries. Supply of healthcare providers was assessed in reports from the SUNY-Albany Center for Health Workforce Studies, the University of Wisconsin/Robert Wood

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Johnson Foundation and the NYS Office of Mental Health. Listings of health and community service organizations from the 7 2013 County Health Department CNAs were reviewed for accuracy by CNA subcommittee members, who also assisted in primary data collection through their support for the conduct of focus groups and the distribution of brief, anonymous surveys at their agencies on clients' experiences with the health care system.

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	14	7
2	Ambulatory surgical centers	3	2
3	Urgent care centers	7	4
4	Health Homes	4	2
5	Federally qualified health centers	2	0
6	Primary care providers including private, clinics, hospital based including residency programs	461	236
7	Specialty medical providers including private, clinics, hospital based including residency programs	705	495
8	Dental providers including public and private	105	9
9	Rehabilitative services including physical therapy, occupational therapy, and speech therapy, inpatient and community based	69	16
10	Behavioral health resources (including future 1915i providers)	45	12
11	Specialty medical programs such as eating disorders program, autism spectrum early	2	0
12	diagnosis/early intervention	8	6
13	Skilled nursing homes, assisted living facilities	38	11
14	Home care services	87	8
15	Laboratory and radiology services including home care and community access	40	19
16	Specialty developmental disability services	31	17
17	Specialty services providers such as vision care and DME	74	13
18	Pharmacies	98	4
19	Local Health Departments	7	5
20	Managed care organizations	6	1
21	Foster Children Agencies	11	3
22	Area Health Education Centers (AHECs)	2	1

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.

14 hospitals serve the region, with half in the LCHP PPS. The region has 461 primary care physicians, but this number varies greatly by county and most of the LCHP counties have populations designated as primary care and mental health professional shortage areas

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(HPSAs). Six of the counties are sparsely populated over large areas without comprehensive public transportation, making it difficult for patients to receive health care services. Even in more densely populated areas, public transportation is an issue. The region lacks urgent care centers with seven overall and four participating in the PPS. An increase of urgent care centers and access to primary care providers through same-day appointments with increased hours of operation, weekend hours and 24 hour access to clinical advice is needed. The service region has 705 specialty medical providers but due to provider shortages, some specialties take months for an available appointment and pediatric specialists are limited in the region. Recruitment of additional providers is desirable.

3 counties do not have inpatient maternity services, requiring travel to neighboring counties for delivery. Only 1 hospital in the region provides neonatal continuing and intermediate care. The 7 LCHP hospitals provide emergency coverage across the region, though the southern part has poor geographic access. 3 ambulatory surgical centers exist in the region with 2 participating in the PPS.

The region has limited behavioral health resources with 87 psychiatrists for a population of more than 560,000. Integrating behavioral health and primary care for mild to moderate mental illness through co-location with expanded roles for nurse practitioners, navigators and LCSWs could help meet these needs and reduce psychiatrist demand. GAPs screening tools could be utilized in pediatric practices and school based health centers (SBHCs) to identify MEB disorders. Telemedicine may also mitigate the psychiatrist shortage and geographical barriers. The region has a shortage of inpatient psychiatric units with only 1 hospital providing services. A Mobile Crisis Assessment Team serves six LCHP counties to alleviate crisis situations but is located in the northern part of the region making it hard to reach individuals quickly.

The region has 87 home care service agencies including each county health department. 69 organizations and hospitals have rehabilitative services including physical therapy, occupational therapy and speech therapy.

The number of dentists differs by county with Delaware and Schoharie counties ranking the lowest in the region. Geographic access for dental care is difficult in rural areas, many communities have no access to fluoridated water and financial barriers to treatment costs exist. Some providers within the region do not accept Medicaid. A few SBHCs have begun dental services but more is needed. Mobile dental screening with low cost for preventive services would increase access to care, and LPNs could apply fluoride varnish during routine pediatric well child visits.

Section 3.3 - Community Resources Supporting PPS Approach:

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

***Resources 1:**
Please provide a count both of the resources in the community in general, as well as resources that are part of the PPS Network. Use the table below. Add rows for additional Resource Types.

#	Resource Type	Number of Resources (Community)	Number of Resources (PPS Network)
1	Housing services for the homeless population including advocacy groups as well as housing providers	73	15
2	Food banks, community gardens, farmer's markets	192	0
3	Clothing, furniture banks	12	3
4	Specialty educational programs for special needs children (children with intellectual or developmental disabilities or behavioral challenges)	46	12
5	Community outreach agencies	175	19
6	Transportation services	17	1
7	Religious service organizations	9	3
8	Not for profit health and welfare agencies	154	18

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#	Resource Type	Number of Resources (Community)	Number of Resources (PPS Network)
9	Specialty community-based and clinical services for individuals with intellectual or developmental disabilities	13	8
10	Peer and Family Mental Health Advocacy Organizations	9	2
11	Self-advocacy and family support organizations and programs for individuals with disabilities	26	11
12	Youth development programs	23	7
13	Libraries with open access computers	86	0
14	Community service organizations	364	57
15	Education	322	23
16	Local public health programs	7	5
17	Local governmental social service programs	7	2
18	Community based health education programs including for health professions/students	54	8
19	Family Support and training	46	7
20	NAMI	4	0
21	Individual Employment Support Services	33	10
22	Peer Supports (Recovery Coaches)	7	3
23	Alternatives to Incarceration	17	0
24	Ryan White Programs	0	0
25	HIV Prevention/Outreach and Social Service Programs	11	4

***Resources 2:**

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

Food is a basic human need and access to grocery stores in rural areas is limited particularly for those with low-income, seniors, and those with no car. The cost of food at convenience stores is typically higher than in supermarkets, and nutrient dense foods are scarce. The greater risk of making unhealthy food choices can lead to overweight or obesity and undermine disease management and healthy lifestyles. Food pantries in low-income neighborhoods contain highly processed and preserved foods high in salt and fat. Most Farmers Markets and community gardens are seasonal or as weather permits. Better access to affordable, healthy choices is a priority for this PPS.

Housing services and resources are less abundant in sparsely populated and low-income areas where the need lies. The age of housing stock, scarcity of assisted and supportive living facilities, and housing for the homeless are concerns. Those of low SES with asthma/COPD may live in conditions that exacerbate the condition such as black mold. There is little community awareness about resources to address this issue and a deficit of advocates for those in need.

Awareness is a major concern with regard to resources. People don't know services exist and communication is lacking. An online, centralized system that conveys basic services, that is easy to navigate and can be searched by county is needed. The public has to be aware of its existence and how to find it; and high traffic locations would benefit from resource specific print copies. Case Managers and Care Coordinators would benefit from a guide that provides more detailed information such as the population served and capacity.

Transportation is a major concern in rural areas, preventing the Medicaid population and the uninsured from receiving healthcare when needed. Great distances to travel, no personal vehicle, limited public transportation, can't afford gas, limited options and long wait times for Medicaid transportation are some of the difficulties. Specialty health services are often unavailable locally. The PPS would benefit from more transportation services for those with mental illness, developmental disabilities, and the handicapped; public transportation with extended hours, more frequency of service and fee waivers for low-income residents would also be beneficial.

There is a need for peer support and mental health advocacy in this PPS and few organizations to meet the need. NAMI has 4 affiliates to cover the area, and only 1 program (Family Support Group) is currently offered in LCHP counties. MCAT services are stretched over vast distances, and a phone help-line is often inadequate in a crisis. Urgent care, walk-in clinics and prime care office hours are limited. Physicians are overloaded with patients and have no available appointments for those who phone needing immediate attention and are told either by an answering machine or a triage nurse to go to the ER. Expanded crisis services, clinic and urgent care hours are needed

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to reduce visits to the ER.
Ryan White Programs do not exist in this PPS. The area would benefit if applications were submitted.

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:

Unless otherwise noted, the data on community demographics are estimated from the American Community Survey (ACS) conducted by the US Census Bureau during the years 2010-2012. The Leatherstocking Collaborative Health Partners (LCHP) will serve a population of 563,774 residents in 7 counties of central New York State (NYS): Chenango, Delaware, Herkimer, Madison, Oneida, Otsego and Schoharie. All of the LCHP counties have an age distribution skewed toward older ages. This is evident in the range of median age in the counties (39.7-45.8 years, compared to 38.0 for NYS) and the percentage of the population aged 45-64 years (an average of 29.7% compared to 26.8% for NYS) and the percentage 65 years of age and older (16.6% compared to 13.8%). The aging of the LCHP population also is progressing more rapidly than for the state, with the median age having increased by an average of 4 years since 2000 in the LCHP counties compared to an increase of 2.1 years for all of NYS.

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

In the 6 counties other than Oneida County, the population recorded as White ranges from 94.5% to 96.7%, Hispanic ethnicity is 3% or less and these values have been stable since 2000. In contrast, 86.7% of Oneida County residents are White (compared to 90.2% in 2000) with 5% Hispanic ethnicity. The city of Utica has an active relocation program for refugees, particularly with Vietnamese, Russian and Bosnian immigrants. ACS data on language spoken at home indicate 12.3% of Oneida County respondents use a language other than English. The most common categories of alternative languages are other Indo-European, Spanish and Asian. A significant proportion of these individuals reported speaking English "less than very well" (33% of Spanish speakers, 41% of other Indo-European language speakers, and 65% of Asian language speakers). The racial and ethnic communities in Oneida County may have specific needs for effective communication on topics related to health and healthcare.

***Demographics 3:**
Income levels:

The median household income in the LCHP counties ranges from $40,949 to $52,121, with all counties falling below the median for NYS ($56,657). Using the approximate quartile cutpoints for the income distribution in NYS (<$25,000; $25,000-$49,999; $50,000-$99,999; > $100,000), the LCHP households are relatively overrepresented in the first three income categories (26.4%, 26.8%, 32.3%). The cutpoint for the top quartile of NYS households (> $100,000) was only attained by an average of 14.3% of households in the LCHP counties, suggesting a compression of the household income distribution rather than a downward shifting of the entire distribution. The relatively small percentage of adults with college or advanced degrees in the LCHP counties, to be summarized below, and the limited occupational opportunities associated with higher levels of education may account for the underrepresentation of higher income households in the LCHP region.

***Demographics 4:**
Poverty levels:

In the LCHP counties poverty among families ranged from 6.8% (Madison) to 11.6% (Herkimer and Oneida), in comparison to 12% for NYS. The prevalence of poverty was higher for individuals than families, averaging 13.8% in the LCHP counties and 15.6% in NYS. As observed for the family data, individual poverty prevalence was lowest in Madison (10.5%) and highest in Oneida (16%) and Herkimer (15.4%). Census data from 2000 show that Madison County has consistently had the lowest prevalence of poverty among LCHP counties, whereas the excess levels of poverty in Herkimer and Oneida have newly emerged in the past decade. As additional indicators of low income, the prevalence of Medicaid coverage and the percentage of uninsured in the LCHP counties (8.1% and 8.9%, respectively) were also lower than the estimates for NYS (11.4% and 10.9%), though the percentage of uninsured was somewhat higher in Chenango

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(11.5%) and Delaware (10.2%) than the other counties.

***Demographics 5:**

Disability levels:

Higher levels of disability might be expected in the LCHP counties in general due to the greater percentage of the population at older ages, and this was true for the prevalence of disability in the total population (10.8% in NYS; a range of 10.3% - 15.9% in the LCHP counties, with an average of 13.8%). However, estimates within younger age categories also revealed excess disabilities affecting the LCHP populations. The average prevalence in 5-17 year olds was 6.7% (compared to 4.6% for NYS), with cognitive difficulties accounting for the majority of disabilities in this age group. In 18-64 year olds, the average prevalence of disability (11.4%) again exceeded the prevalence for NYS (8.4%), with ambulatory, cognitive and independent living difficulties most often cited. In the oldest age group (> 65 years of age) the most common forms of disability were ambulatory difficulty, diminished hearing and difficulties with independent living.

***Demographics 6:**

Education levels:

Key milestones in educational attainment are high school graduation or higher and bachelor's degree or higher. With respect to the former measure, the percentage of adults 25 years and older with a high school degree or more ranged from 85.8% to 90.8% in the LCHP counties, with all counties exceeding the NYS value of 85.1%. However, adult residents of the LCHP counties were less likely to have completed or gone beyond a college education – the average percentage was 22% and the highest value (26.4%, Madison) was well below 33% for NYS. Among LCHP counties, Madison County also had the highest percentage (17.2%) of households in the top income quartile for the state - supporting the connection between education and increased access to more highly compensated jobs.

***Demographics 7:**

Employment levels:

A final socioeconomic indicator for LCHP counties is employment, based on the civilian non-institutionalized population 16 years of age and older (the ACS also measures the military labor force, which is extremely small in the LCHP counties). The percentage of the population that is not in the labor force is relatively high in the LCHP counties, ranging from 37.9% to 43.2% compared to 36.6% for NYS; this clearly reflects the older age of the LCHP population, but may also include individuals who are unable to work due to disability (increased prevalence noted above) or the unemployed who are no longer actively looking for employment. The average unemployment percentage within the civilian labor force of the LCHP counties was 9.3%, similar to the value for NYS for that time period (9.5%). Unemployment was lower in more urban Oneida and Madison Counties (8.6% and 5.3%, respectively) and was highest in the more sparsely populated counties (Delaware 10.8%; Schoharie 12.8%).

***Demographics 8:**

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

The 2010 Census report on Group Quarters gives general information on institutionalized populations within each county. For NYS, the major institutionalized populations are in nursing/skilled nursing facilities (50%) and correctional facilities for adults (41%). The corresponding percentages for the LCHP counties are reversed (51% correctional, 35% nursing) due to the location of state prison facilities in upstate New York counties. The socio-demographic profile of each institution in the LCHP counties is also very distinct. For the 7,267 individuals in correctional facilities, 99% are men, 97% are ages 18-64, 50% are Black, 33% are White and 30% are Hispanic. Nursing facilities have 5,354 residents, with 73% women, 94% 65 years of age or older and 98% White and non-Hispanic.

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

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

File Name	Upload Date	Description
22_SEC034_BassetDSRIPdem.xlsx	12/19/2014 12:10:25 PM	Census socio-demographic data on LCHP Counties
22_SEC034_GroupQuarters.xlsx	12/19/2014 12:11:08 PM	Census group quarters data on LCHP Counties

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Section 3.5 - Community Population Health & Identified Health Challenges:

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

***Challenges 1:**
Leading causes of death and premature death by demographic groups:

The 10 leading causes of death in the LCHP counties, ranked by number of deaths, were heart diseases, cancers, chronic lower respiratory diseases (CLRD), cerebrovascular diseases, unintentional injuries, influenza and pneumonia, diabetes, Alzheimer's disease, kidney diseases and hypertension. The leading causes below 65 years of age were cancers, heart diseases, unintentional injuries, suicide, CLRD, liver diseases, diabetes, congenital malformations and conditions originating in the perinatal period. The top 2 causes for overall and premature mortality accounted for over half of all deaths and were also the leading causes in each LCHP county.

Limited variation on race/ethnicity in the LCHP counties precluded statistically meaningful mortality comparisons by these characteristics. Comparisons of mortality for men and women revealed consistency for the leading 2 causes (heart diseases and cancers, respectively) but differences in other important causes. Cerebrovascular diseases and Alzheimer's disease were more highly ranked causes for women (#3 and # 5, respectively) than men (#5 and #9) while fatal unintentional injuries were more common for men than women (#4 vs. #7).

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

The rate of potentially preventable adult hospitalizations (PQIs) in the LCHP counties was 196.3/10,000 for Medicaid enrollees. This value would be near the bottom (worst) quartile (43 of 62) in the rankings for all 62 NYS counties on this measure, and 3 LCHP counties (Herkimer, Oneida, Otsego) were in the bottom quartile of counties. The rate of preventable child hospitalizations (PDIs) for the LCHP Medicaid population was relatively better (21.1/10,000; would be 31 of 62), with 2 LCHP counties (Delaware, Otsego) in the least favorable county quartile. The PQI for the total adult population (a domain 4 metric), also ranked poorly (139.2/10,000; would rank 46 of 62), indicating gaps in timely and effective primary care affecting all residents. Multiple data sources on preventable hospitalizations from LCHP nursing homes and home health agencies also revealed higher than expected admission and readmission, suggesting need for improved policies, practices and co-ordination within the provider community. The most significant trend data in hospitalization was the rise in drug-related hospitalizations, with 6 of 7 LCHP counties showing an increase of 62% or more over 7 years.

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

Ambulatory care sensitive conditions underlie potentially preventable ED visits (PPVs) as well as PQIs and PDIs, and the rate of PPVs for Medicaid enrollees in LCHP counties was 44.0/100. In the NYS county ranking of PPVs from 1 (best) to 62 (worst), this value would rank 38, and 5 of 7 LCHP counties were also in the lower (worse) half of the rankings. Data on separate PQI conditions showed asthma/COPD, heart failure and diabetes as the major causes of preventable Medicaid hospitalization, accounting for 60% of admissions in 2011 and 2012. The high levels of hospitalization or ED visits for these conditions can result from especially high prevalence of the conditions or unsuccessful medical care and self-management. The UHWS data on a random sample of residents of LCHP counties suggest both explanations are true for Medicaid beneficiaries. The conditions and the risk factors for the conditions (e.g. smoking, hypertension, obesity) are more prevalent for Medicaid recipients. Among all adults with asthma and diabetes, those with Medicaid were more likely to have ED visits and hospitalizations for these conditions in the previous year.

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

The prevalence of chronic conditions most strongly associated with Medicaid-related preventable ED visits, hospitalizations and readmissions were of particular interest. In analyses of UHWS data on 18-64 year olds, prevalence of provider-diagnosed asthma was 2 times greater in Medicaid enrollees than adults with other insurance (16.9% vs. 8.8%). Disparities in prevalence by insurance status (with less favorable levels for Medicaid) were also noted in UHWS data for COPD (7.6% vs. 2.1%) and diabetes (10.2% vs. 4.9%). Prevalence of hypertension was similar by insurance status despite the Medicaid enrollees being on average 7 years younger (40.8 vs. 47.7). Prevalence of heart failure was not measured in the UHWS, but the domain 4 metric on hospitalization for acute myocardial infarction may serve as an indicator of diminished myocardial function potentially leading to heart failure. The LCHP counties had an overall rate of 15.7/10,000 for this measure (equivalent to a rank of 32 for the NYS county rankings), with 4 of the LCHP counties ranked in the lower

(worse) half.

The % of adults with > 14 poor mental health days in the past month (the domain 4 metric for mental health) was 11.3% in LCHP counties, which would rank near the bottom (worst) quartile (44 of 62) in the rankings of NYS counties on this measure. The UHWS included the same measure and allowed for separate prevalence estimates by insurance status; in adults 18-64 years old, the prevalence in Medicaid beneficiaries was almost 5 times greater than the prevalence in adults with other types of health insurance (20.5% vs. 4.2%). A similar disparity between Medicaid and other insurance in UHWS data was observed for provider-diagnosed depression (38.2% vs. 10.8%) and anxiety disorders (25.7% vs. 6.4%).

Joint analyses of mental health outcomes and chronic physical conditions were also possible in the UHWS data and underscore the importance of a comprehensive approach to health care. The presence of each mental health outcome (depression, anxiety, frequent poor mental health days) was consistently associated with increased prevalence of diabetes, asthma, hypertension and elevated cholesterol (as well as behavioral risk factors smoking and obesity), demonstrating the need for better integration of primary care and behavioral health services.

The rate of newly diagnosed HIV cases in LCHP counties during 2010-2012 was 3.8/100,000, based on 64 cases (32 in Oneida County, 32 in the other 6 counties). The rate in all 7 counties was below the rate for NYS counties outside of NYC (6.7/100,000). This pattern of data for frequency and county distribution was similar for gonorrhea, with the majority of cases in the most populous county (Oneida) and county-specific rates all below the rates for upstate NYS counties. Rate for chlamydia in LCHP counties for women 15-44 years old was 1088.4/100,000 in 2012, which would correspond to 32 in the ranking of 62 NYS counties. There was substantial variation by county, with 4 LCHP counties in the quartile with lowest rates and 3 counties in the bottom (worst) half of rankings on this measure.

***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:

2012 infant mortality in LCHP counties was 5.9/1000 live births, compared to 5.4/1000 for upstate NY, but the LCHP rate included only 34 deaths (17 in Oneida, rate=6.5/1000, 17 split among the other 6 counties). Interpretation of maternal mortality is also problematic due to few outcomes (5 deaths in LCHP counties). Prevalence of preterm birth was highest in Oneida County (12.9%, 10.9% for upstate NY), but all other LCHP counties were at or below the 2017 Prevention Agenda (2017 PA) goal of 10.2%. All LCHP counties were above the 2017 PA goal for % of infants exclusively breastfed in the hospital (48.1%), all were at or below the 2017 PA goal for adolescent pregnancy (25.6/1000 live births) and the average % of births with adequate prenatal care (75.3%) would rank in the top quartile of NYS counties. Health insurance coverage ranged from 95% to 96% for children and 87% to 90% for women. The LCHP counties had less favorable rankings on 2 other DSRIP domain 4 metrics, % of unintended pregnancies among live births (34.4%) and % of live births that occur within 24 months of a previous pregnancy (23.5%), suggesting possible needs related to family planning and contraception use.

***Challenges 6:**

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

Domain 4 metrics include prevalence of obesity (for children/adolescents and adults) and prevalence of smoking by adults – LCHP counties have unfavorable levels for these risk factors in the general population. The overall prevalence of obesity in LCHP counties was 27.3% for adults and 19.6% for children, which would correspond to rankings of 30 and 38 respectively when compared to NYS county rankings from 1 (best) to 62 (worst). Data on smoking were even more extreme, with the aggregate LCHP prevalence of 23.3% corresponding to a county rank of 44 out of 62 (and 5 LCHP counties in the bottom quartile of counties, with prevalence ranging from 23.8% to 25.2%). Data from school districts also showed high levels of smoking and unsuccessful quit attempts by adolescents. Residents of LCHP counties tended to be at median levels or worse for other health-related behaviors, e.g. binge drinking, use of clinical preventive services. In addition, for all of the risk factors summarized, the random survey of households in LCHP counties found less favorable results (e.g. more obesity and smoking, less use of preventive screening) among Medicaid enrollees and the uninsured.

***Challenges 7:**

Any other challenges:

The emphasis on maintaining health throughout the life course shifts somewhat to preserving quality of life as the end of life nears. For this issue, use of hospice services and palliative care were examined in the LCHP counties and opportunity for improvement was

revealed. Analyses of Medicare data for the % of deaths that occur while in hospice care showed a relatively high level for 3 LCHP counties (49%-42%) and markedly low level for 3 other LCHP counties (18%-11%). Surveys for quality improvement programs in cancer centers and nursing homes of the LCHP region also found deficits in levels of discussion and referrals for hospice care as well as management of moderate/severe pain. The need for more resources and better coordination between clinic-based and community-based partners was apparent.

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**.

Domain 2 metrics of preventable services (PPVs, PQIs, PDIs, PPRs) documented shortcomings in primary care for the Medicaid population of LCHP counties. Domain 4 metrics and additional indicators (e.g. drug-related hospitalizations, overlap in prevalence of mental and physical health conditions) demonstrated similar unmet needs of the general population, including mental and behavioral health concerns. These unmet needs may be due to inadequate capacity in terms of the supply of community-based primary care and mental health providers.

Analysis of primary care physician FTEs by the SUNY-Albany Center for Health Workforce Studies was based on a 2013 survey of licensed physicians done with the NYS Departments of Health and Education. Results were reported as primary care physician FTEs per 100,000 population, and counties were ranked 1 (high) to 62 (low) on this measure. Otsego County ranked 3 in per capita supply of primary care physicians (110.0/100,000), but the other 6 LCHP counties were below the median (levels ranging from 68.6 to 41.8/100,000) with 4 counties near or in the bottom quartile (Delaware 45, Schoharie 46, Chenango 49, Herkimer 57). A separate assessment of primary care physicians by the University of Wisconsin and the Robert Wood Johnson Foundation (RWJF) used a different data source (HRSA Area Resource File) but reached similar conclusions: high rating for Otsego County and the cluster of 4 counties near the bottom. The Wisconsin/RWJF study also analyzed supply of other primary care providers (nurse practitioners, physician assistants, clinical nurse specialists) to determine if their numbers increased in places with limited physician supply. This was not true for LCHP counties – 4 remained below the NYS median with 2 (Herkimer 59, Schoharie 62) in the bottom quartile.

Two studies examined supply of mental health providers. In the Wisconsin/RWJF study the ratio of provider to population ranged from 1/694 (Chenango, ranked 24) to 1/2304 (Herkimer, ranked 61). Only 2 LCHP counties were above the median, and 3 were in the bottom quartile. In the 2014 per capita count of licensed mental health professionals by the NYS Office of Mental Health, 2 LCHP counties were at the median (Oneida 31, Otsego 32) and the other 5 were lower (with 3 in the bottom quartile).

The shortage of providers in ambulatory settings could reflect overemphasis on inpatient resources, but this seems unlikely in LCHP counties. The New York Codes, Rules and Regulations 2016 projections for nursing homes identified an unmet need of 611 beds in 5 LCHP counties (Delaware, Herkimer, Madison, Otsego, Schoharie). An excess of 407 beds was reported for 2 counties (Chenango, Oneida), but 2012 occupancy levels (Chenango 94.1%, Oneida 93.9%) did not suggest significant unused resources to date. A review of hospitals in LCHP counties found that bed reductions have been made in recent years in Chenango, Herkimer and Otsego Counties; where reductions have not been made, either occupancy has been very high (e.g. Bassett Hospital) or the bed count was already modest and within the only hospital of the county (e.g. Cobleskill Regional Hospital, Community Memorial Hospital.

***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.

A limited supply of providers is one cause of unmet health needs in the LCHP counties, but Otsego County had an ample supply of primary care physicians and still had rates of preventable Medicaid hospitalizations for adults and children in the least favorable quartile of 62 NYS counties. Two sources of consumer data suggest other causes contributing to unmet health needs. A random sample of patients from 25 primary care clinics in LCHP counties were asked to complete the CAHPS survey on experience with health care. Data were

available on 566 patients for the third quarter of 2014. For statements related to access to care (e.g. ease of getting clinic on phone and scheduling an appointment; convenience of office hours; wait time at clinic), on average only 57% of patients rated their experience as "very good" (the highest possible response). Ratings on communication (e.g. provider used words you could understand; information from provider on medications and follow-up) were better but 27% of patients expressed some degree of dissatisfaction. A second set of consumer input from focus groups with Medicaid enrollees and the uninsured had some of the same concerns (e.g. inconvenient hours, delay in having a scheduled appointment) but also expressed more fundamental barriers – practices closed to new patients, being unaware of the location of urgent care facilities, being uncertain about when care should be sought for different kinds of symptoms and conditions and poor continuity of care when seen by different providers at different visits. Transportation was also a challenge when referrals or providers accepting new patients required travel to a non-local site. The 6 counties besides Oneonta are substantially rural, with population densities ranging from 33 to 112 residents per square mile. Compounding the problem of long distances between destinations is the absence of public transportation. Focus group participants acknowledged the series of incentives when travel can be furnished by ambulance to the ED at flexible hours to be seen without a delay in making an appointment. An additional category of data on causes of unmet health needs is external evaluations of process of care. For example, deficiencies in policies and practices were identified for nursing homes (Nursing Home Quality Initiative) and palliative care (Quality Oncology Practice Initiative).

***Gaps 3:**

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

The overview of causes for unmet health needs identified insufficient capacity (i.e. supply of providers) and problems with delivery of primary care and behavioral health services. Strategies to meet health needs of LCHP counties must address both categories of causes. The addition of new providers will be a blend of traditional positions and individuals assuming new roles designed to increase effectiveness of services. For example, expansion of behavioral health services will require more licensed behavioral health professionals (NPs, RNs, LCSWs) and introduction of behavioral health navigators to guide patients to services (clinic and community-based) that will be needed for their care. The health navigator role will be extended more generally for medical and behavioral needs, and to assist individuals who are non-users of services in addition to those not using resources as effectively as possible.

The commitment to achieving NCQA 2014 Level 3 PCMH standards across primary care practices of the LCHP PPS directly relates to many criticisms cited in the CAHPS surveys and Medicaid focus groups. Same day appointments and flexible hours for routine and urgent care will improve those dimensions of access. Continuity of care is addressed by assigning individual patients to a care team; by identifying a team member to be responsible for coordination of care (another relatively new workforce role); and by tracking the % of visits with the designated clinician or team member. Difficulties with transportation may be reduced by creating telephone or electronic options for patient-provider interaction – these include access to clinical advice and ability to request refills and referrals or get test results without coming to the clinic. Clearer communication will be stressed by assessing the language needs of patients and training team members to work more actively with patients and family members to promote self-care and shared decision making.

A common theme across many projects is to identify existing expertise within the LCHP PPS network and to have these individuals support improvement within their area of service. Examples include primary care practices that have met PCMH standards, skilled nursing facilities that have implemented elements of INTERACT, and hospice organizations with more experience engaging patients and providers in end of live planning.

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).

Stakeholder and community engagement for the CNA commenced with the identification of potential advisors to form the CNA subcommittee. A master list of candidates was compiled using key stakeholders involved in the needs assessments done by LCHP

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county health departments and hospitals for the NYS Department of Health in 2013; the DSRIP partnering organizations list; current inventories of community organizations; and nominations from other DSRIP committees. From the master list 30 members of the CNA subcommittee were chosen; since many members represented agencies serving multiple LCHP counties, each county had at least 8 members from that county or with active professional involvement in that county. The 30 members also represented the 10 community sectors noted as essential for promoting public health in the IOM report The Future of the Public's Health in the 21st Century. The CNA subcommittee was asked for a) consideration of crucial health needs of the population and resources to address needs; b) guidance to obtain additional stakeholder input from community organizations; c) support for input from Medicaid enrollees and the uninsured; and d) assistance coordinating focus groups.

The subcommittee's size and diversity were effective for facilitating the different engagement strategies. During the month of October subcommittee members arranged for a CNA working group member to discuss and receive feedback on DSRIP and the CNA at scheduled or ad hoc meetings of 10 community service organizations within the LCHP counties. To address limited public information on mental health and substance abuse referrals and resources in the LCHP counties, members working in this area made contacts for conducting in-depth interviews with providers from all centers and clinics serving 4 of the LCHP counties. For direct input on healthcare needs and experiences, subcommittee members from 5 organizations with presence in all 7 LCHP counties administered anonymous surveys to their low income clients on healthcare access and utilization; 290 surveys were completed to complement the population-based data already available from the UHWS. In addition to serving as a catalyst for extended community engagement, CNA subcommittee members provided their own critique of CNA summary findings and proposed projects during the process.

***Community 2:**

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

Three focus groups were conducted with residents from Chenango, Delaware and Schoharie Counties. The Schoharie County focus group was organized in collaboration with Schoharie County Child Development Council, with participation by 4 parents and caregivers of children in the Head Start program. The focus groups in Chenango and Delaware Counties were conducted in partnership with the neighboring DSRIP applicant, Southern Tier Rural Integrated PPS, whose region also includes Chenango and Delaware. Adults with Medicaid or no health insurance were recruited (7 in Chenango, 11 in Delaware) via multiple community agencies, e.g. county Department of Social Services, Public Housing Authorities, community health centers. In the 90 minute sessions the moderator led discussion of availability and barriers to healthcare services, what people can do to be healthy, awareness of community organizations with resources for supporting health and experiences using the Emergency Department for health problems. Notes and transcripts from these sessions were compiled for identification of main themes and planning potential projects.

***Community 3:**

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

The stakeholder and community engagement process revealed basic social needs affecting health such as access to healthy foods, adequate shelter and information about resources for health and the healthcare system. Limited sources of transportation in rural areas where all forms of healthcare services (e.g. urgent care, primary care, specialty services) are in short supply and span significant travel distances lead to ambulance transport and ED use as alternative options. Other cited challenges to access and quality of care include practices not accepting new patients, urgent care and walk-in clinics not being open when care is needed, delay in when appointments are available to see providers, too little time with providers (and feeling rushed during the appointment), inadequate continuity of care or co-ordination among multiple providers being seen (e.g. when providers rotate within a site), and deficiencies in the patient/provider relationship (i.e. insufficient cultural competence in provision of care) for Medicaid enrollees, the uninsured and the mentally ill. Difficulties with Medicaid enrollment and reimbursement were expressed by both consumers and providers.

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.

[Mohawk Valley PPS (Bassett)] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
1	Catholic Charities Care Coordination Services (CCCCS)	Provides supports and services to meet the needs of those living with or at risk for HIV/AIDS and other	Catholic Charities Care Coordination Services will be actively involved in

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[Mohawk Valley PPS (Bassett)] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		chronic medical conditions and the needs of their loved ones. This is accomplished by service and programs that include: health home care coordination, intensive and supportive case management; Project Safe Point (syringe disposal, access/exchange services, recovery readiness counseling, treatment access, HIV/Hepatitis testing and opioid overdose prevention); linguistic services (medical interpretation for those with limited English proficiency); housing support services; personal care closet; and emergency financial assistance.	the development and implementation of community-based health navigation services (for both uninsured/non-users of primary care and inefficient users) and care coordination services, particularly drawing on its experience with home care coordination. The CCCCS will also seek to make new connections within the LCHP counties to strengthen the infrastructure in support of mental health and prevention of substance abuse.
2	Mohawk Valley Community Action Agency	Mohawk Valley Community Action Agency offers services in three general areas: Child Development, Housing and Family Resources. Some of the specific programs include: Head Start, Early Head Start; Weatherization; Family Self-Sufficiency; Family Unification; Residential Emergency Services to Offer Repairs to the Elderly (RESTORE); Family Development; Foster Grandparent Program; Runaway & Homeless Youth	The Mohawk Valley Community Action Agency and other community action agencies within the LCHP counties (e.g. Madison and Schoharie Counties) will serve as "hot spots" for initial engagement of the uninsured and low/non-users of primary care services. The front line staff of these organizations will work with other PPS partners to support patient activation, identify financially accessible health care resources and make linkages to primary and preventive care services.
3	Catskill Hudson Area Health Education Center	Non-profit organization that works with community-based partners to address healthcare professional shortages and healthcare workforce development in the 11-county region of New York State	The Catskill Hudson Area Health Education Center will support development and delivery of curricula for new provider roles within PCMH and community-based navigation and care coordination services.
4	Leatherstocking Education of Alcoholism/Addictions Foundation (LEAF)	LEAF is a private, nonprofit, volunteer health organization founded in 1982 to reduce the serious personal, social and economic consequences of alcoholism, other drug addictions and associated problems. LEAF works to identify community needs, advocate for policies that address local problems, and provide a range of programs in Otsego County.	LEAF will share its experience in community education and programs with other organizations as part of the strategy for creating a more diverse and active infrastructure in support of mental health and prevention of substance abuse. LEAF will also participate in the establishment of new resources for addiction withdrawal services in community settings and in the planning and implementation of community-based efforts to promote smoking cessation.
5	University of Rochester Medical Center	The University of Rochester Medical Center is an integrated academic health center that comprises The School of Medicine and Dentistry, including its faculty practice (University of Rochester Medical Faculty Group); Strong Memorial Hospital; Highland Hospital; Golisano Children's Hospital; James P. Wilmot Cancer Center; School of Nursing; Eastman Dental Center; Visiting Nurse Service; Highlands at Pittsford; and Highlands at Brighton.	Through telemedicine strategies with this regional healthplan partner, the PPS can provide access to otherwise unavailable expertise in LCHP counties (e.g. pediatric pulmonologist, addiction treatment specialists) for projects related to asthma and ambulatory services for SUDs.
6	Rehabilitation Support Services, Inc.	Founded in 1979, Rehabilitation Support Services, Inc. provides community-based mental health and	Rehabilitation Support Services will be part of the network of PPS

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[Mohawk Valley PPS (Bassett)] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		substance abuse services in 12 upstate NY counties. Its goal is to improve the quality of life for individuals with disabilities through housing, work, care coordination, treatment, socialization, and wellness services.	partners whose clients are likely to be high need patients without insurance or a history of low or non-use of health services. In this role Rehabilitation Support Services will use patient engagement tools to identify individuals to receive support for obtaining insurance coverage and primary and preventive health services.
7	Herkimer County HealthNet, Inc.	Herkimer County HealthNet, Inc works collaboratively with government, health and human service organizations, or other non-profits to complete needs assessments, identify priorities requiring the collective attention of HCHN and its partners, and institute projects/programs to address these priorities	Through its existing connections with multiple community service organizations, Herkimer County HealthNet will serve as a resource for the development of navigation and care coordination services and the community resource database (Community Health Assistance Network).
8	Center for Maternity Services	CMS provides a continuum of services including care for pregnant and parenting adolescents and their families; group residence and family care for children; prevention services and supports for families at risk, as well as daycare services, adoption services, foster care services and respite services. Services are designed to empower clients to reach their full potential by providing them with resources for accessing health, educational and social services.	For its service population, the Center for Maternity Services will support development and implementation of engagement and navigational services for the uninsured/non-utilizing and inefficient users of health services. The Center will also participate with other community-based organizations in development and implementation of co-located services for primary care and behavioral health.
9	Mobile Crisis Assessment Team	The Mobile Crisis Assessment Team provides emergency psychiatric/crisis services to children, adolescents and adults in Oneida, Herkimer, Delaware, Schoharie, Chenango and Otsego Counties. Services are available 24 hours a day, 7 days a week.	The Mobile Crisis Assessment Team will participate with other community organizations working in the areas of mental health and substance abuse and in particular will bring its perspective on opportunities for prevention from its experience responding to emergency circumstances.
10	Herkimer Area Resource Center (ARC)	The Herkimer ARC provides a wide range of quality support services and activities for adults with developmental, physical and psychiatric disabilities such as services coordination, employment services, clinical services, and transportation, among many others.	The Herkimer ARC will offer its expertise to projects involving skilled nursing facilities and home health care, with specific reference to its service population. The Herkimer ARC also provides transportation services for their population of need, and will provide guidance on strategies for addressing transportation barriers in other areas of the LCHP region.

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

Mohawk Valley PPS (Bassett) (PPS ID:22)

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.

[Mohawk Valley PPS (Bassett)] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
30	Need to strengthen primary care to meet PCMH 2014 standards	The PQI measures of potentially preventable hospitalizations are indicators of timely utilization of effective primary care, and the PQI rates for Medicare beneficiaries and the general population of the LCHP counties clearly indicate shortcomings in access and effectiveness. The UHWS data for adults with Medicaid show their greater needs in terms of chronic conditions and risk factors, more difficulty managing chronic conditions (resulting in ED visits and hospitalizations) and lesser use of preventive services. The uninsured also have higher levels of risk factors and even lower utilization of preventive screenings. The CAHPS surveys of patients and the focus groups with Medicaid and uninsured residents of LCHP counties reveal possible areas of improvement – help with transportation; more flexible hours for being seen; better channels of communication before, during and after appointments; and more continuity and coordination of care. Efforts to respond to these concerns will happen in an environment with a current relative shortage of primary care physicians and other types of primary care providers.	PQI Suite – composite for Medicaid and general population PPV – potentially preventable ED visits (Medicaid) Press Ganey CAHPS surveys on access to care and quality of care UHWS: Prevalence and management of chronic conditions and use of preventive services Focus groups – Delhi, Norwich, Cobleskill
79	Need community health navigation for more efficient use of health services	The LCHP counties in aggregate exhibited high levels of potentially preventable adult hospitalizations for the general population (139.2/10,000) and Medicaid enrollees (196.3/10,000). Both PQI rates would rank near the bottom (worst) quartile of rankings for the 62 NYS counties. The rate of potentially preventable Medicaid ED visits for the LCHP counties (44.0/100) would also rank in the least favorable half of NYS counties. In the UHWS data comparing 18-64 year old Medicaid beneficiaries with adults who had other types of health insurance, the Medicaid subgroup was less likely to use preventive services, more likely for diabetes and asthma to require hospitalization and ED visits and more likely to miss medical appointments due to problems with transportation. CAHPS surveys from a random sample of primary care patients in LCHP counties	PQI Suite – composite for Medicaid and general population PPV – potentially preventable ED visits (Medicaid) UHWS: Prevalence and management of chronic conditions and use of preventive services Press Ganey CAHPS surveys on access to care and quality of care

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[Mohawk Valley PPS (Bassett)] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		found additional potential causes for inefficient use of services – frequent less than high ratings for the patient's ability to contact clinics, schedule appointments and fully understand providers' explanations for medication use and follow-up care.	
80	Need to bring the uninsured and low/non-utilizing Medicaid population into community based care	The Medicaid population of LCHP counties has unfavorable levels of domain 2 metrics for potentially preventable ED visits, hospitalizations and readmissions, which reflect disproportionate lack of timely and effective primary care. The UHWS data on random sample of households in LCHP counties suggest that a proportion of the Medicaid population is likely to be infrequent or non-utilizers of healthcare services – 17% reported not having a regular provider, and 25% to 46% had not received cancer screening services in the previous 2-5 years (specific % and time period varied with each screening modality). The UHWS also provided data on uninsured adults, who were even more isolated from the healthcare system. Only 58% reported having a regular provider and 39% of those individuals needed to see a physician in the previous 12 months but did not go due to cost. Non-use of preventive service was even more common for these individuals than for Medicaid enrollees. Additional information on experience and perceptions of Medicaid enrollees and the uninsured came from 3 focus groups conducted in LCHP countries. Reluctance to use primary care services was related to lack of transportation; closed practices, delays in getting appointments at clinics accepting patients or inconvenient hours for service; and feeling rushed and not cared for when being seen. Barriers for the uninsured were the process of obtaining and using insurance and the affordability of out-of-pocket costs.	PQI and PDI Suite – Medicaid population PPV – potentially preventable ED visits (Medicaid) PPR – potentially avoidable readmissions UHWS: Prevalence and management of chronic conditions and use of preventive services Focus groups – Delhi, Norwich, Cobleskill
81	Need for reducing hospitalizations of residents from skilled nursing facilities	The rate of potentially preventable readmissions (PPRs) is particularly relevant for nursing homes as frequent sites for discharge from hospitals, and the Medicaid-specific PPR for hospitals of LCHP counties was 5.7 per 100 at risk admissions, which would correspond to 79th (or 41st percentile) in the rank ordering of 192 NYS hospitals. In more direct evidence on nursing homes, the Nursing Home Quality Initiative of the NYS Department of Health provided ratings for the state's facilities on frequency of potentially avoidable hospitalizations and prevalence of risk factors that may lead to hospital transfer. For the 10 nursing homes in the LCHP DSRIP project, 5 were in the 2 lowest (unfavorable) quintiles on avoidable hospitalizations, 8 were in the bottom quintiles for residents experiencing one or more falls with major injury and 7 were in the bottom quintiles for residents with moderate to severe pain.	New York State Department of Health, Nursing Home Quality Initiative PPR – potentially avoidable readmissions HANYS report: NYS Partnership for Patients Readmission Diagnostics Herkimer Healthnet analysis of discharge planning services

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[Mohawk Valley PPS (Bassett)] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		Another data source on hospitalizations was the HANYS report to NYS hospitals for the federal Partnership for Patients program. This analysis of PPRs by site of discharge prior to readmission showed greater than expected PPRs from nursing homes for 8 of the 10 leading causes of readmission to the largest hospital of the LCHP PPS. A study of policies and practices in nursing homes by a PPS partner organization, the Herkimer County Healthnet, found several gaps in follow-up procedures with patients, families and community providers that might impact risk of readmission.	
82	Need more effective home care services to reduce hospital readmission for high risk patients	The rate of potentially preventable readmissions (PPRs) for Medicaid patients in LCHP counties was 5.7 per 100 at risk admissions; in the rank ordering of 192 NYS hospitals (from most to least favorable) this rate would correspond to 79th (or 41st percentile). Additional detail on Medicaid PPRs was available from the HANYS Partnership for Patients report on hospitals of the Bassett Healthcare Network (including 5 hospitals in LCHP counties). When compared to NYS rural hospitals and all NYS hospitals on the leading causes of PPRs, the Bassett hospitals frequently had higher rates of readmission (e.g for 8 of 10 leading causes in 2012, 7 of 10 in 2013). When the data were examined by discharge site before readmission, greater than expected rate of PPRs were found for patients discharged to home health care for almost all the leading causes of readmission. The hospital-based data were consistent with CMS reports on home care patients served by a major home health provider in LCHP counties. In the CMS data, risk-adjusted improvements in client symptoms and status (e.g. management of medications, reduction in dyspnea and pain) were consistently smaller in comparison to the national reference home care population, while ED use and hospitalizations were higher. An analysis of discharge planning services identified gaps in process that might affect transitions from home care, and low utilization of hospice services may be a factor in excess hospitalization for home care patients.	PPR – potentially avoidable readmissions HANYS report: NYS Partnership for Patients Readmission Diagnostics At Home Care CMS risk-adjusted outcome report Herkimer Healthnet analysis of discharge planning services Hospice Analytics report on % of Medicare deaths occurring in hospice
83	Need to better integrate primary care and behavioral health services	Domain 4 metrics (frequent poor mental health days, binge drinking and suicide mortality) all have unfavorable levels for the general population of LCHP counties. An emerging indicator of behavioral health concerns in the general population is the sharp increase in drug-related hospitalizations in 6 of 7 LCHP counties in the last 7 years. UHWS data provide population-based evidence that mental health problems are more prevalent among adult Medicaid enrollees than adults with other health insurance. More significantly, when the UHWS	BRFSS: Prevalence of poor mental health days and binge drinking Vital Statistics: Suicide mortality SPARCS: Drug-related hospitalizations UHWS: Association of mental health diagnoses with chronic physical conditions and risk factors

Mohawk Valley PPS (Bassett) (PPS ID:22)

[Mohawk Valley PPS (Bassett)] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		analyses examine mental health diagnoses and chronic physical conditions and risk factors simultaneously a strong association is observed: individuals with mental health diagnoses (e.g. depression, anxiety disorders) or frequent poor mental health days are much more likely to also have diabetes, asthma, hypertension, elevated cholesterol, and risk factors such as smoking and obesity. This pattern of co-morbidity applies for both Medicaid and other types of insurance, and is also consistent with Salient data for the LCHP counties on the prevalence of mental health and substance abuse disorder diagnoses among Medicaid beneficiaries with chronic conditions. These findings are a powerful rationale for co-location of primary care and behavioral health services, with a related need to increase the supply of behavioral health providers.	NYS Office of Mental Health: mental health providers per population
84	Need for community based substance use disorder (SUD) withdrawal management services	In the domain 4 metrics for mental health and substance abuse, the prevalence of binge drinking by adults in LCHP counties was nearly 20%, which would correspond to a rank of 37th in the rank ordering of NYS counties (with 1-62 as most to least favorable). Prevalence of heavy drinking by adults was also reported by NYS county in the expanded BRFSS, and 6 of the 7 LCHP counties had a prevalence exceeding the age-adjusted value for NYS (5.0%), with Oneida County at 11.3%. Drug-related hospitalization rates in LCHP counties have risen dramatically in the past 7 years. The % change between 2003-2005 and 2010-2012 was 5% for upstate NY counties combined, but greater than 60% for 6 of the 7 LCHP counties with the prevalence nearly doubling in 4 counties (Chenango, Herkimer, Otsego, Schoharie) during this time period. The drug-related hospitalizations in LCHP counties during this time period accounted for 3009 admissions. Similar time trends were observed for poisoning hospitalization rates and neonate drug-related hospitalization rates. In the LCHP counties timely initiation of treatment for alcohol and other drug dependence (a domain 3 behavioral health metric) was achieved for 79% of Medicaid recipients needing such care, which would rank in the lower (less favorable) half of NYS counties on this measure. Interviews during the CNA process with SUD service agencies in 4 LCHP counties revealed limited local capacity as a major challenge in making successful referrals.	BRFSS: Prevalence of binge drinking and heavy drinking SPARCS: Drug-related hospitalizations HEDIS: Domain 3 clinical metrics on behavioral health In depth interviews with community agencies receiving and making SUD referrals
85	Need to implement evidence-based guidelines for asthma management	The LCHP counties have a high overall rate of potentially preventable Medicaid hospitalizations and asthma/COPD is a major component of that excess rate. When examined separately, the three asthma-related Medicaid hospitalization rates across	PQI Suite–composite PQI05 Asthma/COPD hospitalization in older adults PQI15 Asthma

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[Mohawk Valley PPS (Bassett)] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		the age range are all elevated in comparison to other counties of the state. In addition to having excessive rates of asthma-related hospitalization by Medicaid enrollees, several LCHP counties experienced increased rates of ED visits for asthma from the general population. The UHWS based on a random sample of households in the LCHP counties found that adult Medicaid enrollees were twice as likely to report provider-diagnosed asthma compared to adults with other types of insurance. The UHWS data were also consistent with the PQI and SPARCS findings on asthma and avoidable use of services, showing that Medicaid beneficiaries with asthma in the LCHP counties were four times more likely to have an ED visit for asthma in the previous year than asthmatic adults with other insurance coverage. Exposure to second-hand smoke is an important asthma trigger and focus for self-management, and BRFSS data indicated that the percentage of homes where smoking was allowed was relatively high for LCHP counties compared to the rest of NYS.	hospitalization in younger adults PDI14 Pediatric asthma hospitalization SPARCS:Asthma ED visit rate UHWS:Prevalence of asthma and asthma ED visits by Medicaid status BRFSS:Prevalence of exposure to second-hand smoke
86	Need for increased access to palliative care programs in PCMHs	A 2010 report by Hospice Analytics on the % of Medicare deaths occurring in hospice not only showed large variation across 62 NYS counties but also revealed that the full range of variation was present in the 7 LCHP counties - 3 counties had the highest percentages in the state (49%, 43%, 42%) while 2 counties had the lowest percentages (13%, 11%). A similar pattern was observed in the 2011 report, suggesting geographic areas for focused intervention and local availability of expertise to promote hospice services. Additional data on end of life care was from for the American Society of Clinical Oncology (ASCO) Quality Oncology Practice Initiative. For management of dyspnea, pain and hospice discussion and enrollment, the performance of the regional cancer center was worse than the aggregate data on all institutions included in the initiative. Less than optimal management of pain in the LCHP counties was also noted in data on nursing homes from the Nursing Home Quality Initiative and data on home care patients from CMS quarterly reports on patient outcomes. The separate DSRIP projects for nursing homes and home health agencies, and their proposed involvement in the palliative care project, will likely produce synergy among institutions for improved management of pain and support for palliative care services. Also underscoring need in this area is the prominence of COPD and heart failure, common hospice diagnoses, as important causes of hospitalizations and readmissions.	Hospice Analytics report on % of Medicare deaths occurring in hospice ASCO Quality Oncology Practice Initiative: Measures of care at end of life PQI Suite – composite Nursing Home Quality Initiative: Long-term residents with moderate/severe pain At Home Care CMS data on Management of Pain
87	Need to strengthen mental health and	The LCHP counties in aggregate ranked unfavorably	BRFSS:Prevalence of

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[Mohawk Valley PPS (Bassett)] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
	substance abuse infrastructure	on all 3 domain 4 metrics for mental health and substance use, particularly for % of adults with frequent poor mental health days – 11.3%, equivalent to 44th in a NYS ranking from 1 (best) to 62 (worst). The combined LCHP county rankings for binge drinking and suicide mortality would also be in the lower (less favorable) half of county rankings. The BRFSS did not have measures of other drug use, but trends in drug-related hospitalization have increased very dramatically in the past 7 years in 6 of 7 LCHP counties, likely reflecting emerging challenges in abuse of prescription and illicit drugs. The domain 4 metrics mentioned above were specific to adults. Several LCHP counties have shared data from the YRBS administered in schools, and these data show significant levels of tobacco use, alcohol consumption and extended feelings of sadness. A challenge to strengthened mental health and substance abuse infrastructure is the very limited supply of behavioral health providers in most of the LCHP counties. The scarcity of providers was documented independently in analyses by the NYS Office of Mental Health and the University of Wisconsin/Robert Wood Johnson Foundation, and was confirmed in by participants in focus groups and organizational meetings during the needs assessment process.	poor mental health days and binge drinking Vital Statistics: Suicide mortality SPARCS:Drug-related hospitalizations YRBS:Poor mental health days, suicidal thoughts/actions, use of tobacco, alcohol and other drugs NYS Office of Mental Health: mental health providers per population
88	Need to promote tobacco use cessation, especially for persons with low SES or poor mental health	Prevalence of smoking by adults is markedly high throughout the LCHP counties, and is likely to be a factor in the importance of asthma and COPD as major causes of preventable ED visits and hospitalizations. More detailed information from the UHWS shows that among adults 18-64 years of age the prevalence of smoking is significantly higher among Medicaid enrollees and the uninsured than individuals with other types of health insurance, reflecting a strong SES gradient in tobacco use. Additional stratification of UHWS data by measures of mental health indicate that individuals with provider-diagnosis of depression, anxiety disorders or self-report of frequent poor mental health days are also much more likely to smoke. Surveys in the community have found smoke-free policies generally adopted by private multi-unit housing but resisted by public housing sites (where low SES population is more likely to reside). The few smoking cessation programs that exist in LCHP counties report low levels of participation. In addition to the information about adults, surveys in several school districts have documented not only the levels of smoking by adolescents but also an interest in quitting and a high percentage of unsuccessful quit attempts among current young smokers.	BRFSS:Prevalence of smoking BRFSS:Prevalence of exposure to second-hand smoke UHWS:Prevalence of smoking by Medicaid status and mental health YRBS:Prevalence of smoking and unsuccessful quit attempts by high school students Bassett Tobacco Program: summary of smoking cessation programs and policies

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

DSRIP PPS Organizational Application

Mohawk Valley PPS (Bassett) (PPS ID:22)

File Upload: (PDF or Microsoft Office only)
Please attach the CNA report completed by the PPS during the DSRIP design grant phase of the project.

File Name	Upload Date	Description
22_SEC038_FINAL_LCPH CNA Dec2014.pdf	12/21/2014 03:01:27 PM	Final CNA Document

Mohawk Valley PPS (Bassett) (PPS ID:22)

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: **MIBasset_Section4_Text_Mohawk Valley PPS AKA Leatherstocking Collaborative Health Partners_ Section 4 Part1.docx**

Description of File

Section 4, Part 1 - Eleven projects text

File Uploaded By: swathirg

File Uploaded On: 12/21/2014 12:30 PM

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

Currently Uploaded File: **MIBasset_Section4_ScopeAndScale_Mohawk Valley PPS AKA Leatherstocking Collaborative Health Partners_ Section 4 Part2.xlsx**

Description of File

Section 4, Part2 - Speed and Scale Docuemnt

File Uploaded By: swathirg

File Uploaded On: 12/21/2014 11:57 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.

The projected 25% reduction in hospitalizations and ER use over five years will shift the demand for labor from the inpatient, acute care setting to the outpatient, ambulatory setting. An impact study conducted by the Workforce Committee has indicated that the total number of reduced admissions and ER visits will be relatively small; therefore LCHP does not expect that it will lead to workforce reductions. Excluding Little Falls Hospital, where the rate of potentially preventable readmissions is 6.31, rates for the other hospitals in the LCHP service area are below the statewide average of 6.31. These include A.O. Fox (4.66), Chenango Memorial (5.63), Cobleskill Regional (5.77), Community Memorial (5.07), Delaware Valley (3.52), Faxton-St. Luke's (5.26), Margaretville (2.49), Bassett (5.53), O'Connor (0), Oneida Health Care (3.59), Rome Memorial (4.65), and St. Elizabeth (5.43). A number of workers from inpatient, acute care settings will

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be redeployed to emerging roles in primary care, patient navigation, quality improvement/ quality assurance, hospice and long term care. Preparation for the change in roles will require enhanced training, such as motivational interviewing and behavioral health screening tools as behavioral health is integrated into the primary care setting. As new roles emerge in palliative care, redeployed staff will require training and skills needed to communicate with patients about dying and to help them negotiate end of life decisions. LCHP will implement a number of measures to minimize the negative impact of system transformation on the existing workforce. All employees will be given advanced notice of LCHP implementation, which will be shared with the appropriate labor representatives. This information will be compiled and distributed to the LCHP partners by the Collaborative Learning Committee, in conjunction with the workforce implementation team. Job descriptions will be developed based on project-specific care delivery models. LCHP will analyze staffing gaps and develop solutions to address staffing needs. Department managers seeking to fill vacancies will meet with interested employees individually to review job requirements, identify gaps in skills, develop individualized training plans and discuss the availability of financial assistance. Every effort will be made to redeploy displaced employees with LCHP. All employed by LCHP will have access to an existing online warehouse of available training resources. The engaged workforce impact consultant will work closely with the Collaborative Learning Committee to identify opportunities, risks and solutions resulting from LCHP implementation. Navigation out of LCHP will be the least desirable and final option. Workers leaving the PPS will be given a transition period during which they will receive assistance with their external job search. These measures will minimize negative financial and emotional impacts on the existing workforce. LCHP has identified a number of workforce categories that will be impacted by LCHP implementation. Psychiatrists, social workers (LCSWs), nurses, patient navigators, RNs, and other advanced practice clinicians will need to fill expanded roles within the 11 projects. Clinical and non-clinical staff in the acute care setting will be impacted by the transition of care from the acute setting to the outpatient setting. These employees will be redeployed to assume positions in the non-acute care setting Staff will receive necessary clinical training in new models of care (Interact, PCMH). LCHP will impact both union and non-union positions. Union leaders will be engaged throughout the redeployment and retraining processes.

***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.

LCHP will develop a Learning Collaborative Committee that will identify all project workforce requirements and work with local colleges and other organizations (including the Catskill Hudson AHEC) to develop certificate programs, provide diverse and robust training programs for project staff, and explore recruitment strategies. LCHP is committed to working with employees and stakeholders, including labor representatives. LCHP member organizations will post available positions, offering current employees the first opportunity to apply for open positions prior to posting them externally. The LCHP Project Management Office will maintain a list of available positions, working collaboratively with LCHP partners regarding employment opportunities. LCHP will implement a multi-pronged recruitment strategy including, but not limited to, participation in job fairs, electronic and print notification. Additionally, LCHP will collaborate with local schools including SUNY Cobleskill, an LCHP partner, to promote employment opportunities. The lead agency, Bassett, has a long-standing relationship with SUNY Delhi and Hartwick college nursing programs, as well as the New Visions program in local secondary school districts. LCHP will utilize search firms to recruit clinical staff for critical vacancies necessary to fulfill the project requirements.
There are several workforce shortages that exist in the LCHP service area, including a dearth of primary care, mental health, and dental providers as defined by the HRSA for HPSA. A primary care workforce that includes advanced practice clinicians will be required for each of the eleven projects. The recruitment of RNs and social workers is a challenge in rural central NYS. Care managers are needed to support care transformation, yet the pool of experienced RNs is limited. The shortage of palliative care–certified health care professionals in the service area will pose a challenge to implementation of Project 3.g.i. The workforce impact consultant will be engaged to develop and recommend strategies to mitigate these challenges. Additionally, LCHP partners are experienced in effectively responding to the work force challenges in their rural service area and will work collaboratively to develop innovative regional strategies and service delivery models. Recruitment of specialty providers in LCHP's region (i.e., pediatric pulmonologist - project 3.d.iii, board-certified addictionologist, project 3.a.i.v.) will be challenging. In order to address these challenges, LCHP will address the expansion of services through the successful pilot project utilizing telemedicine. LCHP will implement a multipronged approach (including schools, websites and career fairs) to meet recruitment goals. LCHP will engage multiple stakeholders in mitigating these challenges, including, but not limited to, union representatives, workforce impact consultants and search firms.

***Strategy 3:**

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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	10%
Retrain	55%
New Hire	10%

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 workforce impact consultant will be engaged to identify positions, employees and functions requiring retraining to effectively meet the transformative goals of the projects. In partnership with the Collaborative Learning Committee and LCHP stakeholders (including, but not limited to, union leaders, project teams and human resource personnel), training needs will be identified for all affected employees. Depending on the specific need of the individual and the requirements of the position, LCHP will offer a multi-pronged approach to include access to the learning modules in the existing online warehouse of training resources, certificates and tuition reimbursement for approved degree programs. The lead agency will leverage its relationships with regional colleges to enhance the training programs offered to current employees in an effort to meet evolving healthcare workforce needs. The Collaborative Learning Committee will leverage existing expertise within LCHP to create curricula for onsite training workshops and conferences. External experts will be engaged, as required, for highly specialized training needs. When feasible, a "train-the-trainer" approach will be implemented to reduce unnecessary expense and develop content experts to sustain continuous learning opportunities.

Retraining for LCHP employees will be offered on a voluntary basis. Employees will be encouraged to participate in opportunities for retraining to meet the evolving needs of the workforce. Multiple retraining opportunities will exist within LCHP for employees wanting to enhance their skill sets. In order to maximize their chances of continued employment with LCHP, employees will be strongly encouraged to pursue the training opportunities offered. While this training will be offered to employees on a voluntary basis, employees who decline to pursue these opportunities will do so at their own risk.

***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.

LCHP is committed to having employees maintain existing salary and benefit status, redeploying displaced employees into a role that will require enhanced skills. The workforce impact consultant and union leaders, as appropriate, will be fully engaged in such events so to ensure a fair and equitable process for the affected employee. In the event a change is required that will negatively impact the employee, the change will be evaluated thoroughly to ensure all options and opportunities have been considered. If a required change will negatively impact an employee, it will be evaluated thoroughly to ensure all options and opportunities have been considered. Retraining efforts will be directed at having a positive impact on wages, moving employees into advanced or expanded roles, affording them a greater potential for increased salaries while maintaining a similar benefits structure. Successful project implementation will lead to a greater volume in the non-acute care setting. LCHP will redeploy staff to outpatient setting where their skills can be enhanced to provide optimal patient care.

***Retraining 3:**

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

Ramifications will vary depending upon the volume of work that remains for any given position over the LCHP period. In the event that the volume of work necessitates role restructuring and the employee refuses redeployment, LCHP will assist an employee in finding another position, first within the employee's agency and then within another LCHP partner organization. As a last resort, the employee would continue to be supported in his or her search for a new position outside of LCHP during a transition period, defined by their employment contract or HR policies and ending with a separation date.

***Retraining 4:**

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

The PAC includes union representatives from the New York State Nurses Association and the New York State Health Facilities Association, who were involved in discussions on workforce related issues. LCHP includes one nursing home and one hospital that are unionized. Additionally, the county health departments (LCHP partners) are unionized. LCHP will engage all pertinent labor groups as part of the training needs assessment process, will work with them collaboratively to determine future state skills and training needs, and will partner with them to develop and provide LCHP education and training courses and programs. Their involvement will ensure that the retraining plans will abide by union policies. As job roles are expanded and as some positions are phased out, LCHP will invite these groups to fully participate in developing retraining plans and programs with the goal of maintaining the current workforce.

***Retraining 5:**

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

Placement Impact	Percent of Retrained Employees Impacted
Full Placement	95%
Partial Placement	5%

Section 5.3 - WORKPLACE RESTRUCTURING - REDEPLOYMENT OF EXISTING STAFF :

Description:

Please outline expected workforce redeployments.

***Redeployment 1:**

Describe the process by which the identified employees and job functions will be redeployed.

Redeployment occurs when an employee is displaced from his current position and transferred to another position or entity to perform essentially the same role or function. As the transformative process proceeds and workers are redeployed, LCHP will commit to maintaining employment opportunities within LCHP for eligible employees. Though the transformative process is not likely to have a noticeable effect until Demonstration Year 2, a process will be established with input from the workforce impact consultant and union leaders, as appropriate, and implemented in Demonstration Year 1. Each identified department will prepare an inventory of employees who have been identified for potential redeployment. In areas that are likely to be affected by the transformation, staff will be notified of anticipated changes and corresponding opportunities will be articulated. The process will be transparent and equitable, allowing all employees an equal opportunity. Eligible affected employees will have the opportunity to apply for available positions within LCHP and will be offered opportunities for retraining, as required for the new position. Counseling will be offered to each employee and a transition period will be established.

Employees may be redeployed to new or enhanced positions in several ways. A supervisor may refer an employee to another department with a known staffing need or might identify a potential redeployment opportunity through the online job portal. Alternatively, a hiring manager could become aware of an availability through the Collaborative Learning Committee. The redeployment process will involve a thorough review of the employee's performance evaluations, current training, licensure and education. The interview process will identify an employee's qualifications, interest and fit for a position. Once redeployed, the employee will be given a transition period to complete tasks and close out projects associated with the previous position as he or she begins to adjust to the demands of the new position. During the transition period, employees will be given every opportunity to seek assistance and support as needed (perhaps through mentorships with other employees). The hiring manager will establish performance goals that the employee must meet as part of his or

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her yearly performance evaluations, as would be required of any employee. Employees who do not meet these goals will be issued corrective action plans with due dates for remediation as per established policies.

***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.

Every effort will be made to redeploy employees to positions with comparable wages and benefits. LCHP expects that, with the acquisition of new skills, employees will be qualified to fill positions that offer increased wages, as one strong focus of the LCHP workforce strategy will be on expanding current job roles, not constricting the workforce, or reducing wages and benefits. However, LCHP recognizes that salary structures and benefit plans will vary among partner organizations in LCHP. Therefore, it is possible that employees who are redeployed to a different organization may be subject to salary and benefits structures that differ relative to their original organization and that their accrued benefits may not carryover. LCHP will consult with the applicable unions, as appropriate, in order to ensure that the redeployments are aligned with relevant regulations and guidelines and are fair to existing employees.

***Redeployment 3:**

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

If an employee refuses redeployment, LCHP will assist them in finding another position, first within the employee's current place of employment, but also presenting opportunities with other LCHP partner organizations. As a last resort, LCHP will establish a transitional period (with a separation date) during which it will assist the employee in identifying a potential position outside of LCHP. Separated employees with good employment records will have access to the job portal and will be given hiring preference for positions for which they qualify for one year after their separation.

***Redeployment 4:**

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

The PAC includes union representatives from the New York State Nurses Association and the New York State Health Facilities Association, who are involved in plans and strategies on workforce related issues. One nursing home, one hospital, and the county health departments in LCHP have unionized employees. LCHP will invite representatives from affected labor groups to participate in the redeployment assessment and planning process to ensure that these processes abide by union policies.

Section 5.4 – WORKPLACE RESTRUCTURING - NEW HIRES :

Description:

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

***New Hires:**

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

The new jobs to be created will fit into several categories across LCHP including: LCHP organizational management, LCHP project coordination, direct patient care, community-based navigation, and external contractors. Administrative, technical and management positions will include operations, IT/systems analysts, compliance/risk management analysts and financial analysts. LCHP project coordination positions will include project managers for each of the 11 projects as well as workflow supervisors and QA/QI staff to implement and drive rapid cycle evaluations. Direct patient care positions may include physicians (e.g., an addictionologist for project 3.a.iv), nurses (e.g., RN care coordinators for several LCHP projects), case managers, navigators and other health care providers. A number of community-based positions will be needed to 1) meet patient recruitment goals targeting uninsured patients and low-Medicaid utilizers; 2) facilitate relationships with stakeholders and project partners. External contractors may be needed to fill any positions not otherwise filled within LCHP.
LCHP has a strong focus on patient navigation and is well-positioned to leverage the skills of several categories of potentially redeployable employees with health or human service backgrounds. For example, as a result of the community needs assessment, and through discussions with project committees, LCHP will create navigator positions that will assist patients and their families in seeking information and/or guidance on issues and health-related needs. The navigator may assist the patient at his or her initial point of entry or at points of

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transition between health care providers. The position may also function as an integral component of the patient's ongoing care. These new roles will provide linkage along the care continuum to ensure consistency of care including, but not limited to, psychiatric and/or substance abuse problems. Key tasks will include conducting needs assessments for patients and family members, working with the patient and the primary care provider to identify treatment options and to initiate a treatment plan, assisting the patient in making and keeping appointments, monitoring service access, linking patients to needed community services, assisting patients in obtaining financial resources (including participation in patient assistance programs), and assisting them in applying for and obtaining health insurance. Navigators may provide wellness case management, patient advocacy and chronic disease management. Candidates with training in human services, nursing, social work, marriage and family therapy, or psychology will highly sought after for these positions.

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	32
IT Staff	9
Mental Health Providers Case Managers	175
Nurse Practitioners	20
Other	9
Physician	5
Social Workers	19

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	250,000	650,000	875,000	500,000	225,000	2,500,000
Redeployment	25,000	65,000	87,500	50,000	22,500	250,000
Recruiting	12,500	32,500	43,750	25,000	11,250	125,000
Other	25,000	65,000	87,500	50,000	22,500	250,000

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.

The LCHP workforce strategy is focused on retention of eligible LCHP employees wanting to remain employed by the LCHP partner organizations, through retraining or redeployment, and hiring employees with hard-to-locate skill sets through multi-pronged recruitment efforts. Bassett has worked with the New York State Workforce Investment Board (SWIB) in the past in order to obtain information on various programs that are available to fund retraining and will continue to do so again as the lead agency for LCHP. For example, LCHP has already identified one potential source of training funds listed on the SWIB, the New York State Department of Labor Dislocated Worker Training National Emergency Grant, and a funding opportunity through which applicant entities from sparsely populated counties will provide occupational training to dislocated workers, with health care being identified as a focus area receiving top funding priority. As the rural location of the LCHP presents challenges to filling many health care roles, dislocated workers in the LCHP service area could represent one underutilized recruitment pool. Further, Bassett has worked with AHEC to promote medical technology degrees and has also availed of funding through Doctors Across New York to populate physician positions that are hard to fill in the rural service area. LCHP anticipates that it will continue to work with these and similar programs to fill nursing, social work, navigator, and physician roles that will be needed to meet LCHP project goals.

Section 5.7 - Stakeholder & Worker Engagement:

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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.

During the planning phase, a Workforce Steering Committee comprising 10 members representing hospitals, providers of services for the developmentally disabled, long-term care, hospice services, and nurses, was created. The stakeholder engagement process included representation of nurses and attending physicians, who participated in project planning as members of project subcommittees through regular meetings held during the LCHP planning phase. Finance supported the project subcommittees with collecting and analyzing workforce budget/FTE needs data. Project subcommittees (e.g., Project 2.b.vii, Project 2.a.ii and Project 3.a.i) also engaged frontline content experts from the community who had experience implementing similar projects (e.g., INTERACT) at their facilities. These experts helped the project committees identify workforce and training needs, as well as recruitment strategies.

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

During the planning phase, LCHP engaged Bassett's Vice President for Human Resources, Sara Albright. Ms. Albright consulted with the American Society for Healthcare Human Resources Administration (ASHHRA) and has integrated their best practices and recommendations into the LCHP workforce strategy. ASHHRA is a clearinghouse of research and best practices for healthcare human resource professionals that convenes clinical and health systems experts, compiles data to inform policy papers, and makes recommendations on the primary care workforce needs (including workforce planning and labor relations). LCHP will continue to consult ASHHRA as it implements retraining and redeployment over the LCHP period. Representatives from the New York State Nurses Association and the New York State Health Facilities Association were involved in workforce strategy planning. For example, the Project 2.b.vii team has consulted with the New York State Health Facilities Association to identify its workforce needs specific to long-term care).

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

During the planning phase, representatives of attending physicians, nurses, other advanced practice clinicians, and administrative staff participated in project subcommittees. As project plans were developed, the subcommittees also engaged frontline content experts from the community to share their experiences in implementing similar projects. Based on needs identified in the Community Needs Assessment, focus groups and key informant interviews were conducted to understand workforce needs and gaps in services. Several subcommittees collected and analyzed planning survey results to assess the capabilities of participating providers and invited representatives experienced in implementing key components of potential LCHP projects to speak as guests at their planning meetings. LCHP will continue to engage physicians, nurses, other advanced practice clinicians, patient navigators, and administrators through focus groups, surveys, in-depth interviews, and offline discussions with the project subcommittees. Communication between the frontline and the LCHP Project Management Office will continue as system change is implemented.

***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.

LCHP will continue to engage stakeholders and workers through focus groups, surveys, Town Hall meetings and continuing education courses and programs. Representatives from non-partner organizations will be welcomed and encouraged to serve on LCHP committees. Staff and consumers will be engaged through the Collaborative Learning Committee (CLC) and the Consumer Committee, respectively. Staffing will present a barrier. Existing staff will need to develop new skills and LCHP will likely need to use recruitment firms to fill some positions. LCHP will ensure that the partner organizations work together as much as possible to fill needed positions.

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

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

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

☑ Please click here to acknowledge the milestones information above.

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

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

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

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

Scoring Process:

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

Section 6.1 – Data-Sharing & Confidentiality:

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

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

LCHP will ensure care quality and coordination using federally- and state-compliant data-sharing plans. To ensure that LCHP's PPS partners act in unison to safeguard data privacy and security, and to uphold all regulatory requirements including HIPAA privacy provisions, the LCHP has established the Information Technology and Data Analytics Subcommittee (ITDAS). The ITDAS will finalize a data sharing plan which will describe consent and change management approaches (documenting consent and authorized changes through administrative logs, etc.); incorporate federally- and state-compliant usage agreements; develop diverse data-sharing methods to ensure interconnectivity while guarding data security; outline processes for monitoring compliance with pertinent regulations and channels for implementing corrective action when necessary; and implement a consistent and universal data privacy and security training program.

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

To ensure privacy and security, all LCHP partners will uniformly use Business Associate and Data Use Agreements, which the ITDAS will finalize and oversee. LCHP will conduct an IT security audit to evaluation and mitigate risks. As LCHP will bring together diverse organizations and a diverse workforce, training will be necessary to ensure data privacy, security and universal adherence to HIPAA privacy provisions across LCHP. Training will include sessions on patient consent, HIPAA and data security. The ITDAS will work with the Collaborative Learning committee to incorporate these elements into the training provided to all LCHP personnel. This training will be based upon Bassett's already established regulatory training, but will be revised to include the diverse needs of the partner organizations and workforce.

***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.

LCHP will leverage diverse resources to ensure interconnectivity, enabling real-time sharing of relevant information to support efficient and effective patient care while meeting all security and privacy standards. Since it is unlikely that any single method of data-sharing will

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suffice for the diverse needs of LCHP, multiple methods will be used to coordinate patient care across the LCHP network and to ensure HIPAA privacy. LCHP will explore a number of strategies including health information exchanges (HIEs) and HIE interconnections (leveraging the regional SHIN-NY/RHIO); direct messaging using Meaningful Use (MU)-compliant electronic health records (EHRs) and health standards profiles to share data with partners who do not have EMR/fax capability; a service bureau to provide EMR access to providers currently using paper records or non-MU certified products that preclude data sharing; data warehousing; an enterprise master patient indexing system to share patient identifiers and records across disparate systems; and population health software to track medical and social needs. Working with the Project Management Office to implement and document authorized systems changes, LCHP will integrate a number of approaches to promote real-time data sharing through a comprehensive infrastructure including networked servers and easily controllable, user friendly data selection menus and navigation portals. To meet the goals of the targeted projects the infrastructure will be equipped to aggregate patient information from a diverse set of partner organizations including core performance measures reportable by all partners within DY 1.

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 PAC appreciates that rapid cycle evaluation (RCE) for LCHP will facilitate system transformation. This will occur through the quick evaluation of successes and failures, and by the subsequent adaptation, adoption, or abandonment of process elements through iterative cycles of "Plan- Do- Study- Act (PDSA)." Over the course of the LCHP timeline, the Clinical Performance Operation Committee will be ultimately responsible for reporting RCE results to the Executive Committee and for making recommendations on further actions that may be taken to improve LCHP performance. Since the RCE will involve diverse measurements of both clinical and financial performance, the RCE processes will necessitate close collaboration between the Clinical Performance Operation Committee, the Information Technology and Data Analytics Subcommittee (ITDAS), and other standing committees, such as Finance, Workforce and Compliance. The Clinical Performance Operation Committee is a standing committee that operates under and reports to the Executive Committee.

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

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

The performance of LCHP partners and providers will be evaluated using the MAPP PPS-specific measurement portal and claims-based data that will be incorporated into RCE to track performance indicators on a monthly basis. Through RCE, LCHP will evaluate productivity, utilization, costs, referrals, and appropriate and timely care management. RCE will focus on core project-specific clinical performance measures and will inform incremental, well-controlled adaptation, adoption or abandonment of project elements. LCHP will use performance dashboards to respond proactively to event alerts. Based on key LCHP baseline population health metrics, each project will implement evidence-based interventions to improve the health of their respective targeted populations. Claims or referral data will be used to contact Medicaid consumers directly through telephone calls, letters and home visits.

***RCE 3:**
Describe the oversight of the interpretation and application of results (how will this information be shared with the governance team, the Providers and other members, as appropriate).

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Each project team will report RCE results to the Clinical Performance Operation Committee monthly/quarterly. This will allow for input regarding clinical interpretations, recommendations, and subsequent incremental changes. The Clinical Performance Operation Committee will render its approval and submit recommended changes to the Executive Committee. The ITDAS will generate an integrated, interactive LCHP PPS dashboard and sub-dashboards that will present summarized RCE results overall, and for each project and committee, respectively. These dashboards will be presented to the Executive Committee and could also be shared with providers and other members of LCHP through interactive links using the LCHP web site.

***RCE 4:**

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

RCE will be critically important in reaching 90% Value-based Payment by the end of the LCHP period. The RCE approach will afford the rapid maturation of the PPS through the introduction of well-controlled, incremental changes at both the programmatic and system-wide levels. This will be accomplished through three consistent mechanisms: 1) upstream reporting from providers, the project teams, the Clinical Performance Operation Committee, and, ultimately, the Executive Committee; 2) downstream communication from the Executive Committee to the standing committees; and 3) lateral communication amongst providers and between project teams. LCHP will use the results of RCE to disseminate best practices to its partners. Ultimately, by incrementally adapting, adopting or abandoning process elements, LCHP will accomplish the LCHP goals for the service area.

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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.

Specific cultural challenges in the service area include low literacy; low health literacy; a small, but growing, Hispanic community; several developmentally disabled populations located in residential communities; and geographic isolation from available health care services. Additionally, the service area faces rural poverty, particularly in Herkimer, Otsego, and Oneida Counties (with federal poverty rates of 15.8%, 15.7% and 15.4%, respectively higher than the State average of 15.1%). The service area's average unemployment rate (7.7%) is higher than the rest of the State (6.9% excluding NYC). In addition to these challenges, the service area includes 18 Jehovah's Witness congregations and nine Amish settlements (Association of Religion Data Archives, 2010) including two settlements of Old Order Amish residing in Otsego County. Health care delivery could be impacted by prohibition of blood products among Jehovah's Witnesses, while cultural factors such as discomfort in high-tech settings and reliance on horse and buggy could impact health care delivery for over 12,000 Amish residing in NY State (Amish Studies, Elizabethtown College). Previously, four Muslim congregations in the service area accounted for approximately 1% of the population (ARDA, 2010). As this population continues to grow, especially in Delaware and Oneida Counties, LCHP must incorporate strategies for addressing its cultural norms for diet, dress and social interaction (Taheri, N. 2008). Bassett, LCHP's lead agency and the primary Health Benefit Exchange enrollment site for Herkimer County, is experienced in meeting these challenges to provide culturally competent services to patients, as are the other LCHP partners.

***Competency 2:**

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

With increased cultural diversity in LCHP's service area, there is a strong need for culturally competent care coordination and patient navigation services that will be sensitive to the beliefs and practices of the areas scattered ethnic and religious groups. The LCHP Workforce Committee, under the oversight of the PAC, will develop and implement training, aligned with the National CLAS Standards, to ensure the cultural competency of frontline workers, and will make hiring bilingual workers in Spanish or other prevalent languages a priority. LCHP will network with community organizations to identify the best ways to respond to the challenges presented by the increasing religious diversity in the service area, including the growing Muslim population. LCHP has identified a variety of online resources, including the NYLearnsPH.com Learning Management System (LMS) and the Empire State Public Health Training Center (ESPHTC), which it will incorporate into its comprehensive training program. LMS allows learners to identify online public health training opportunities relevant to their specific job roles. ESPHTC is an academically-affiliated educational center offering continuing education credits through free and publically available cultural competency and health literacy online modules. LCHP will develop its capacity for culturally competent nursing care coordination by providing training through the Duke University Population Care Coordinator Program, which will be tailored to the specific needs of LCHP. LCHP will integrate resources into a cultural competency training program engaging all employees, with an emphasis on culturally competent care coordination and navigation.

***Competency 3:**

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

LCHP has entered into partnerships with numerous community-based organizations representing the cultural diversity of its service area population. For example, Catholic Charities of Chenango County provides Medicaid service coordination to individuals with developmental disabilities. In Delaware County, Southern Tier Care Coordination offers care management to eligible Medicaid participants with a variety of chronic health conditions and participates in the Health Homes program connecting community members with health care providers. LCHP has also partnered with Herkimer County ARC, Pathfinder Village, and Springbrook, who provide services and care coordination to people with intellectual disabilities. LCHP will network with other community organizations (across the State if needed) to identify the most appropriate community organizations to address the challenges posed by the area's increasingly diverse cultural and religious groups. The LCHP Workforce Committee will utilize the expertise of its partners who serve diverse populations to develop cultural competency standards, consistent with the National CLAS Standards, to be incorporated into service contracts, which will be reviewed and approved by the PAC. A training session will equip all partners with tools to integrate these standards into their organizational policies. Partners contracting with LCHP will be required to adhere and attest to these cultural competency standards as one of their contract provisions. LCHP will explore contracting with a number of partner organizations, integrating LCHP-specific cultural competency training at the appropriate level of intensity according to each organization's role in the planned activities.

Section 7.2 – Approach to Improving Health Literacy:

Description:

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

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

***Literacy:**

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

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

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- Describe how the PPS will contract with community based organizations to achieve and maintain health literacy throughout the DSRIP Program.

LCHP's plan for improving and reinforcing health literacy will adhere to best practices as recommended by the United States Department of Health and Human Services and to its 15 National Standards for Culturally and Linguistically Appropriate Services in Health Care. LCHP partners acknowledge cultural differences and present health information in a socially and culturally appropriate manner. Materials will be updated routinely to reflect social and cultural norms, factoring in the age, cultural diversity, language, and literacy skills of the LCHP population. Health literacy will be reinforced by using the "read back" method, in which the patient is asked to restate the message, ensuring it is understood. Open-ended questions will be utilized to identify domains in which patients need further clarification. LCHP partners will utilize a professional interpreter service to communicate with patients in their native language, while ensuring that facility signage has universal symbols promoting ease of flow through facilities. Staff will be trained to create and sustain a respectful and shame-free environment where patients and staff feel comfortable and safe. LCHP will leverage existing relationships with regional organizations (i.e., Rural Health Network of Central New York, Inc.) it its effort to reduce disparities and improve health literacy for the State's rural populations. Partners will engage LCHP's Learning Collaborative Committee to optimize recruitment and retention of staff representing the demographics of the service area.

Health literacy is a critical component of patient safety and will be a key factor in LCHP's mission for health improvement. Current processes established to monitor and improve health literacy will be enhanced through mandatory staff and provider education, data collection and information management. Patient safety incidents will be reviewed for possible health literacy implications. The Clinical Performance Committee will engage project teams in establishing and incorporating specific health literacy metrics. These metrics will include compliance with recommended screenings, medication regimens, and follow-up care plans, among others. Patient satisfaction surveys will be administered to gauge the degree of health literacy in LCHP's population and the extent to which patients are engaged in their care. These data will be stratified on race, ethnicity primary language and religious affiliation, where applicable (i.e., Jehovah's Witnesses). Partners not meeting the standard will be required to submit a corrective action plan to the Executive Governance Body.

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.

LCHP will establish a model for flow of funds based on six budget categories, with fund distribution planned over the five year period based on project implementation and the development of the project management office. Over the demonstration years, budget values will fluctuate based on achievement of performance goals, revenue losses, services not initially covered, and unanticipated occurrences that will arise. A significant portion of the funds are allocated to revenue loss and bonus payments, to be disbursed as transformation takes hold and partners meet their metrics, while others experience revenue loss. Implementation costs are factored in to ensure project plans are supported and able to sustain their work throughout the program. The funds flow model provides 95% of funding to safety net providers.

Each project chair will be responsible for developing a budget based on anticipated project revenue/losses and expenses required to meet the metrics of the project. Input will be obtained from all participating partners on the project for review by the project chair and Finance Committee. Funding for partners and projects will be based on contribution to the success of the projects. To drive LCHP success, there will be a considerable percentage of DSRIP pool funds allocated for performance which exceeds requirements. There will thus be an alignment between performance, outcomes and remuneration.

The Finance Committee will develop the flow of funds model, the distribution of funds, the process for revenue shifting, and the methodology for incentive distribution based on feedback from the project teams. The Committee will oversee the budget process, compiling and summarizing financial information for reporting to the Executive Governance Body (EGB). The EGB will monitor revenue, expenses, and outcomes to ensure that funds are being used effectively toward the mission of the LCHP. The EGB will approve the funds flow model recommended by the committee prior to the distribution of funds.

To transform the healthcare system, providers and community based organizations must collaborate to meet the goals and metrics of each project. The proposed model gives voice to all partners, including those without attribution, in support of the transformation. The

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funds flow model supports revenue loss for sustainability during the transformation, as well as allocation to key partners needing financial support. Partners who meet or exceed their metrics will be rewarded, while those not meeting the performance standards will receive reduced funding until a determination can be made as to why they are not meeting their metrics. The distribution of funds will be made across the continuum of care to all types of partners with the intention of benefiting the Medicaid and uninsured populations. The provision of innovation funds will allow providers to pilot promising new programs in response to identified community needs.

Section 8.2 – Budget Methodology:

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

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

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

#	Budget Category	Percentage (%)
1	Cost of Project Implementation	25%
2	Revenue Loss	17%
3	Internal PPS Provider Bonus Payments	37%
4	Contingency	10%
5	Costs of services not covered	9%
6	Innovation	2%
	Total Percentage:	100%

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

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

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

Please click here to acknowledge the milestones information above.

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SECTION 9 – FINANCIAL SUSTAINABILITY PLAN:

Section 9.0 – Financial Sustainability Plan:

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

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

Scoring Process:

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

Section 9.1 – Assessment of PPS Financial Landscape:

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

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

Based on an initial financial analysis conducted by the Finance Committee, including financial data, sources of funds, baseline utilization statistics and 2014 average payment rates, the PPS has identified a dozen partner providers with financial reserves of less than 1% above the amount needed to ensure financial sustainability. LCHP is continuing to collect data on the financial status of partners across the LCHP in addition to collecting clinical information and data on workforce requirements. Once this information has been received, the PPS will conduct a baseline sensitivity analysis during DY1to gauge the potential impact of LCHP system transformation. This includes reductions in hospital admissions, emergency service visits, and other types of visits, noting there in some cases there will be an increase in volume. The PPS understands that most of these related costs will be fixed, not variable. LCHP will contract with a financial consultant to evaluate the impact that a rapid transition in volume from inpatient to outpatient will have on its partner organizations, particularly hospitals. Financially fragile partners will be monitored more closely and asked to submit financial improvement plans to the LCHP Finance Committee. Based on the level of financial performance, the EGB will make decisions on partner project participation and may recommend exclusion of specific partners from participation if they are deemed incapable of achieving a project's goals. Further, the EGB may decide to make an allocation of LCHP pool funds to sustain and turnaround a struggling partner.

***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.

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The planned PPS activities and projects will influence financially fragile providers as they seek to fulfill the overall goals of LCHP in the reduction of avoidable hospital admissions by 25%. As a result, hospitals will see a reduction in their inpatient census and emergency services while expanding other services. These changes could result in modification to business lines and workforce redeployment. This shift could be particularly impactful for fiscally challenged facilities. The LCHP projects will influence some financially fragile providers by implementing projects that will result in decreased volumes. The funds flow plan has taken these impacts into account, targeting specific funds categories for those providers who are impacted more by project outcomes. The transformation of care will have diverse a effects on providers. For example, project 3.g.i. will integrate palliative care into the LCHP primary care practices that have achieved NCQA PCMH certification, which will reduce hospital readmissions for the target population of 21,184 patients in the service area with chronic and high-risk conditions including hypertension, asthma, diabetes, COPD, coronary atherosclerosis, cancer and well as chronic pain. Project 2.b.vii. will implement Interventions to Reduce Acute Care Transfers (INTERACT) in 10 nursing homes in LCHP, five of which experienced an overall higher rate of potentially avoidable hospitalizations than the LCHP service area – 50% of homes scored in quintile 4 or 5 vs. 40% (CNA). INTERACT will improve the management of changes in residents' conditions, with the goal of stabilizing them and avoiding transfer to an acute care facility. Thus its implementation will reduce hospital admissions resulting in a reduction in hospital revenue. Strengthening of asthma self-management through LCHP project work will reduce avoidable ED and hospital care for the more than 4,040 Medicaid beneficiaries with asthma in the service area with annual hospital admissions, further contributing to decrease in hospital revenue. Emergency service usage will also be impacted by the PCMH 2014 project resulting in shifts in volume and revenue. The integration of behavioral health and primary care will result in reduced hospitalizations for an estimated 11,199 patients. Other categories of partners, for example, home care, may see an increase in volume. In recognition of these shifts in volume and revenue, LCHP will reserve funds to provide incentives and support to financially fragile providers to implement transformational change at the earliest possible date.

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.

LCHP will develop a sustainability plan via recommendations from the Finance Committee in DY1. This will enable identification of restructuring and savings opportunities, while ensuring metrics and milestones are met. The plan will describe how financial metrics will be incorporated into ongoing rapid cycle evaluations. It will describe how performance will be compared to financial benchmarks with a particular focus on detailing how potentially fragile providers will be carefully monitored. The plan will describe how, over the transformational period, LCHP will identify services and programs that could either be reduced, enhanced, integrated or reorganized across organizations to increase their efficiency and it will identify ways to restructure debt and redistribute resources, including staff. The sustainability plan will include a component to generate growth in Medicaid enrollee participation, as well as address the opportunity to engage the uninsured population. The plan will also establish a process of evaluating revenue cycle initiatives for designated LCHP partners in a timely manner, with a focus on determining how these processes may be strengthened, in particular for financially fragile providers. The Finance Committee will submit a finalized implementation plan to the EGB detailing its strategy for financially challenged partners by early DYI. Thereafter, the Finance Committee will provide quarterly reports and documentation outlining successful implementation. There are no known restructuring efforts at this time.

***Path 2:**
Describe how the PPS will monitor the financial sustainability of each PPS partner and ensure that those fragile safety net providers essential to achieving the PPS' DSRIP goals will achieve a path of financial sustainability.

The Finance Committee will develop a financial dashboard status to monitor the financial sustainability of each LCHP partner. The Committee will evaluate financial indicators through partner reporting and will evaluate them against benchmarks monthly. Consequences for negative variation from budget and other financial requirements will include the necessity that the partner submit a corrective action plan with a timeline for remediation. LCHP will contract with a financial consultant to assist in establishing a process through which the projected impact of project plan implementation can be measured. These processes will help ensure that financially challenged providers are identified early on and that provisions are made to provide assistance as needed with appropriate emphasis on safety net providers.

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***Path 3:**

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

LCHP will continue to adopt successful and proven practices during the demonstration years and beyond. The transformational work that will occur during this time will be sustained through existing and expanded partnerships and collaborations across the continuum of care. LCHP will continue to attract Medicaid beneficiaries, identify methods to strengthen the revenue cycle, adopt process efficiency programs such as Lean-Six Sigma, and ensure a high-level of patient satisfaction. The Clinical Performance Committee will continue to monitor LCHP performance with respect to project requirements, domain metrics, and individually selected clinical goals. LCHP will continue to utilize a zero-tolerance-for-avoidable-error approach. Further, it is anticipated that over the demonstration years, competition among partners across PPS' will dissipate and be largely transformed into collaborative partnerships. Early in the demonstration years, LCHP will seek out opportunities to partner with Medicaid managed care organizations and other third party payers to accelerate the movement toward value-based reimbursement.

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

Description:

Please describe the PPS' plan for engaging in payment reform over the course of the five year demonstration period. This narrative should include:

***Strategy 1:**

Articulate the PPS' vision for transforming to value based reimbursement methodologies and how the PPS plans to engage Medicaid managed care organizations in this process.

LCHP's vision for system transformation is to deliver high quality, patient-centered care, linking payment to value, using evidence-based, outcome-driven models of care delivery. The vision includes timely access to affordable care and transparency for beneficiaries in terms of quality, cost and patient experience. System transformation will ensure a seamless transition to well-coordinated care across the continuum, leveraging the power of electronic health records to maintain interconnectivity. The transformation will process will need to be scaled according to resources. Partner organizations will need to incorporate change-management techniques. Importantly, there will be an incentive program to reward outcomes that exceed standards. Through effective strategic planning and success in key performance metrics, LCHP will continually seek to avoid adverse outcomes among its partners. The organization will leverage cost and quality data as a foundation for discussion with Medicaid managed care organizations and other payers. LCHP will assess a variety of reimbursement options, referencing the level of performance of the network, risk-adjusted patient populations, actuarial information, and level of shared risks.

***Strategy 2:**

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

Through effective reimbursement transformation, LCHP and Medicaid managed care organizations will realize shared savings that will yield advantages for all parties. A reduction in overall costs addresses part of the equation toward financial reform and sustainability. With respect to reimbursement, LCHP will assess a number of reimbursement options reflective of the movement toward a value-based approach. Among others, these will include a full and partial capitation model, bundled payments, upside-only shared savings, as well as joint sharing of risk. LCHP will leverage its performance to negotiate reasonable reimbursement with appropriate quality measures to ensure effective system transformation. The total population health model aligns consistently with the planned modification in reimbursement schema with appropriate sensitivity to critical, but financially fragile, partners. With this approach, the needs of vulnerable partners can be effectively addressed. The experience gained through the NYSDOH DSRIP program will be invaluable in catalyzing discussions with other third party payers, thereby creating a path to the desired reimbursement model.

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

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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.

LCHP has not chosen project 2.a.i

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

Recognizing the need to minimize negative impacts to the workforce, Leatherstocking Collaborative Health Partners (LCHP) intends to contract with a proven and experienced organization to help implement its workforce strategy for employee recruitment, retraining, and redeployment. LCHP will also leverage existing resources including the lead agency's established relationships with institutes of higher learning. For example, Hartwick College offers an RN to BSN program and SUNY Delhi offers an LPN to RN program. Drexel University, Empire State College, and the Chamberlain School of Nursing offer multiple programs, most with degrees, and provide discounted tuition for employees. In addition, the lead agency has established partnerships and/or clinical rotations with SUNY Upstate (Medical Technology), SUNY Cobleskill (Histotechnology), Albany College of Pharmacy and Health Sciences (Medical Technology, Cytotechnology), and Broome Community College (Medical Laboratory Technician, Histotechnology). The Central New York Area Health Education Center offers shadowing experiences for high school students interested in laboratory careers as does the hospital-wide New Visions program. Further partnerships have been established with the Albany College of Pharmacy, the SUNY Buffalo College of Pharmacy, Wilkes College of Pharmacy (Pennsylvania) and St Johns Fisher College of Pharmacy. Partnerships in respiratory therapy training have been established with SUNY Upstate, Mohawk Valley Community College and Hudson Valley Community College.

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.

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Delivery System Reform Incentive Payment Project

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SECTION 11 – ATTESTATION:

Attestation:

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

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

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

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

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

Primary Lead Provider Name: MARY IMOGENE BASSETT HSP
Secondary Lead Provider Name:

Lead Representative:	Bertine Mckenna
Submission Date:	12/21/2014 03:20 PM

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