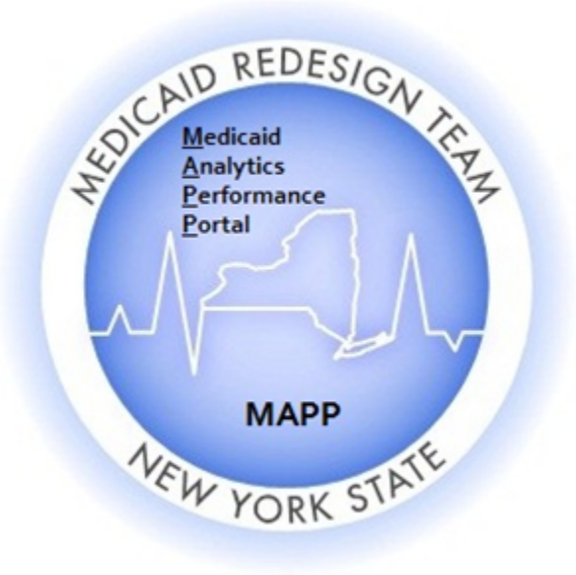
New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP PPS Organizational Application



Refuah Health Center

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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: **20_SEC000_RCHC_DSRIP Financial Stability Test_11-10-2014.xlsx**

Description of File

RCHC Financial Stability Test 11.10.2014

File Uploaded By: refuah
File Uploaded On: 12/19/2014 12:13 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: refuah
Last Updated On: 12/22/2014 03:07 PM

Certified By: refuah
Certified On: 12/22/2014 03:26 PM
Lead Representative: Michal Sperka

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 a high-functioning integrated delivery system in Rockland and Orange Counties	The core of Refuah Community Health Collaborative's (RCHC) DSRIP strategy is to create a high-functioning integrated delivery system (IDS), which will facilitate data-driven population health management across a network of care. This goal is critical because the IDS creates the structure for improvements in care, outcomes and costs. The CNA shows the need for this type of health care infrastructure in our service area, particularly for those with multiple chronic conditions, those with complex cultural and socio-economic circumstances and older adults. Moving from fragmented to integrated care will allow us to better manage care for patients and populations, implement care coordination across the care continuum, enhance collaboration and the use of best practices, and implement systems that allow information sharing and rapid-cycle evaluation. Creating an IDS enables the PPS to reduce hospitalizations, achieve population health goals, improve care delivery and reduce costs.
2	Reduce avoidable hospitalizations by 25%	Reducing avoidable hospitalizations is one of RCHC's primary goals. A focus on reducing hospitalizations drives the implementation of upstream strategies and shifts away from an emphasis on acute care to primary and other types of community-based care. This will enable RCHC to achieve the Triple Aim of better care, better outcomes, and lower costs. Given the high costs of hospitalization, preventing avoidable admissions is critical to creating a delivery system that is sustainable in the long run.
3	Improve indicators in the County Community Health Improvement Plans	Including a goal related to our County Community Health Improvement Plans enables us to focus on developing population health structures and strategies for health care providers and community-based organizations to work together in clinical and community settings. This goal will encompass RCHC's work to improve population health through better care coordination and management, use of advanced analytics and health information technology and exchange, and adoption of proven primary and secondary prevention strategies. In Rockland and Orange counties, conditions such as heart disease, cancer, chronic lower respiratory diseases, and stroke are significant health burdens and among the leading causes of death. Additionally, health disparities among minorities are significant. A comprehensive, patient-centered population health approach is critical to reducing mortality and the burden of disease in our service area, reducing health disparities, and lowering health care costs.
4	Reduce patient wait times and expand access to primary care providers	This goal is at the heart of RCHC's strategy to transform the health care delivery system. Expanding access to primary care and other community-

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#	Goal	Reason For Goal
		based providers are critical components of our strategy to ensure that patients receive the right care, at the right place, at the right time. Effectively utilizing and expanding the primary care resources available in communities throughout the region will reduce unnecessary reliance on inpatient and emergent care. The region has experienced above average population growth in comparison to the rest of the state. This growth has reduced excess capacity and widened gaps in access. Ensuring primary care access, regardless of ability to pay, has become ever more critical in light of this growth.
5	Sustain the PPS through value-based payment agreements with managed care plans in the service area	One of RCHC's primary areas of focus is to embed value-enhancing behaviors throughout the IDS during DSRIP and throughout the post-DSRIP era. DSRIP incentive payments will be used to cover new innovative services that improve outcomes and reduce the total cost of care while sustaining the safety net. The new value-based payment system will continue to incentivize these new behaviors/services to continue DSRIP's accomplishments and sustain the financially fragile safety net providers. To be successful, the value-based payment model must be transparent, reasonable, and flexible and reward high performers.

***Formulation:**

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

RCHC is designed to implement a community-based approach that will focus on the specific needs of Medicaid and underserved patients in Rockland and Orange Counties. This approach will ensure that the new system of care is led by providers with expertise serving the unique and diverse populations of the two counties.

RCHC's comprehensive network includes the full spectrum of health and social service providers. RCHC is an FQHC-lead initiative and includes four premier FQHCs—all with extensive experience in providing culturally competent care to and reducing health disparities for Medicaid patients. These FQHCs will form the foundation of the new delivery system and—in partnerships with other network providers—expand access to community-based services. FQHCs have a proven record of addressing the social determinants of health, reducing disparities, and improving outcomes.

RCHC's governance structure includes representatives from multiple provider types, community-based organizations, unions, and stakeholders to ensure that community needs and disparities can be quickly identified and addressed and to increase collective accountability for patient and population outcomes.

***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.

RCHC's vision is to transform the current fragmented delivery system into one that provides high-quality integrated physical and behavioral health services as well as the supportive and enabling services necessary to address the social determinants of health and health disparities in the service area communities.

To achieve that vision, RCHC will incentivize providers to provide patient-centered and coordinated care in a community-based integrated delivery system. RCHC will develop a highly-integrated care management system that enables providers across the full spectrum of care to manage performance and share data through robust health information technology and exchange systems. Given that the current reimbursement system is one of the reasons that the healthcare delivery system in RCHC's region is siloed, RCHC will develop innovative payment models with managed care organizations in the region to incentivize high performance and develop reimbursement methodologies to support providers for services not currently covered by Medicaid.

***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:

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

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

#	Regulatory Relief(RR)	RR Response
1	14 NYCRR Part 551 14 NYCRR Part 599.3	The PPS will seek a waiver of 14 NYCRR Part 551 in order to co-locate behavioral health in an Article 28 clinic that is not also licensed by OMH under Article 31. It will also seek a waiver of 14 NYCRR Part 599.3 for Article 31 providers seeking to expand primary care services above the 5% of annual visits threshold. This regulatory relief is being sought for two RCHC projects: 3.a.i and 2.a.ii. For Project 3.a.i, one of the primary components of the behavioral health (BH) co-located in primary care model is to institute a universal screening for behavioral health and substance abuse. The screenings are intended to identify behavioral health needs among primary care patients. Once identified, primary care sites must be able to meet these behavioral health needs, which, for most Article 28 primary care sites, will necessitate increasing the amount of behavioral health care they provide. Additionally, co-location is restricted by the volume limits imposed by licensure. These limits restrict providers' ability to implement the co-location and full integration models allowable for this project unless they hold both licenses. Current volume limits need to be increased or waived for RCHC's Article 28 partners in order to allow them to integrate behavioral health services in a meaningful way. For Project 2.a.ii, one of the required components of PCMH certification is integrated behavioral health and primary care. Therefore, the same components and potential impacts as for Project 3.a.i will apply for this project. Alternatives to regulatory relief have been considered; however, the NYS DOH DSRIP Project Toolkit calls for the co-location of behavioral health in primary care as one of the 3 model options under this project. Given the high rates of mental health conditions in the service area, RCHC plans to implement all 3 models, which is aligned with DSRIP goals of broadly enhancing access to behavioral health services. Article 28 providers in the RCHC network already have a track record of providing high-quality, safe, and effective behavioral health services to primary care patients. The requested waiver would merely constitute an expansion of resources already in place, without any adverse impact on patient care or safety. RCHC recognizes that, if granted, an expansion of behavioral health services at its Article 28 providers may require additional staffing and expansion of facilities. This will include new staff, systems (e.g., protocols, standing orders), technology, and programs for integrated behavioral health care. RCHC would collaborate with its Article 31 and

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#	Regulatory Relief(RR)	RR Response
		other behavioral health providers to ensure that policies and procedures are developed and training is given to integrated care team members on such things as suicide protocols, crisis prevention safety, and cultural competency. RCHC will monitor adherence to such policies and procedures through its quality improvement and compliance programs.
2	10 NYCRR 710 10 NYCRR 715 10 NYCRR 754	RCHC will establish an Article 28 birth center to be operated by one of its FQHC partners inside an Article 28 inpatient hospital. This co-location of services by two Article 28 providers would require Certificate of Need (CON) approval and compliance with certain physical plant requirements as a result of co-location. The requested regulatory relief would be for a waiver to exempt the birth center from undergoing the CON process, compliance with certain physical plant requirements associated with co-location of a birth center, or if applicable, an expedited review of the CON application. A key aspect of the Project 2.a.i Integrated Delivery System (IDS) is to ensure access to the full continuum of care. Having a birth center will enable RCHC to fill a gap in the community and implement an effective—and cost effective—model of care aligned with community need and demand. Access to the birth center will be embedded into processes related to care management and coordination. It will also serve as a place for family-based care coordination and patient navigation. CNA data revealed high birth rates in the service area and that maternal/child discharges (e.g., vaginal or cesarean deliveries, newborns with other problems) are among the top 20 Medicaid inpatient discharges in the service area. The creation of an Article 28 midwife-centered birth center located on the campus of one of RCHC's hospital partners will create an alternative to inpatient hospital deliveries. Midwife-centered birth centers, when compared to inpatient deliveries, can reduce costs, reduce cesarean deliveries and labor inductions, and promote patient-centered care for mother and child. A birth center is consistent with the IDS goal to reduce unnecessary hospital use, and a waiver from the requirements of 10 NYCRR 710, 715 and 754 would allow RCHC to include a birth center as part of its IDS. RCHC's network does not currently include any midwife-centered birth centers. The establishment of such a center will be a lower-cost, patient-centered alternative to inpatient hospital deliveries. Locating a birth center on a hospital campus, as opposed to a free-standing center, is critical to ensure the safety of mother and child in the event that higher-level obstetrical services are required. Article 28 providers in RCHC's network already have a track record of providing high-quality, safe care to patients and therefore are uniquely situated to expand this track record to a midwife-centered birth center. The rationale behind the requested waiver is in large part to ensure patient safety and access to higher-level services in the event of complications. RCHC would ensure that the birth center collaborates with other partners in the network to develop policies and procedures that facilitate care provision in an integrated, safe, effective manner. RCHC will monitor adherence to such policies and procedures through its quality improvement and compliance programs.

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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.

Refuah Community Health Collaborative ("RCHC") will begin operations under a Collaborative Contracting Model. The RCHC Steering Committee (the initial governing body of RCHC) considered the Delegated Model and the Incorporated Model, but eventually the Steering Committee determined that the Collaborative Contracting Model is best suited to the start-up of its operation for several reasons. RCHC is a PPS that is led by Refuah Health Center ("Refuah"), a Federally Qualified Health Center (FQHC) with other FQHCs participating as PPS partners. RCHC is not a hospital-led PPS nor does it have an extensive number of PPS partners as compared to other Performing Provider Systems in the State. A significant number of the RCHC partners focus on the delivery of primary care. Given these facts, the Collaborative Contracting Model is a form of joint venture which is most easily adaptable to the limited number of partners (84) in RCHC predominantly engaged in primary care with only 1 acute care hospital partner located in the service area. This model provides great flexibility in contracting with PPS partners and does not require the maintenance of a separate level entity, which can be costly and burdensome. This model permits governance participation from each PPS partner category, while protecting the fiduciary obligations of the Lead Entity and the PPS partner who has made a financial commitment to RCHC. The reasoning behind this choice was explained to

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PPS partners at PAC meetings, and the PPS partners present found it easy to understand and indicated their agreement that it was appropriate for RCHC.

The uploaded organization chart reflects the governance structure, including Refuah as the Lead Entity; the Executive Governing Body; the Project Advisory Committee; the Operations Committee; the Financial Governance, Clinical Governance, Data/IT Governance, and Compliance Committees; and Work Groups (if and when developed by these Committees). The Operations and Compliance Committees were added by the Steering Committee to the basic structure of the Collaborative Contracting Model.

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: **20_SEC021_RCHC Organizational Chart.pdf**

Description of File

Refuah Community Health Collaborative Organizational Chart

File Uploaded By: refuah

File Uploaded On: 12/22/2014 09:53 AM

***Structure 2:**

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

RCHC's goal is to maintain an efficient governance structure, easily understood and accessible to the PPS partners. The roles and responsibilities of the Executive Governing Body, each of the Committees, and the Project Management Office will be clearly defined in writing with appropriate checks and balances. The current Steering Committee will dissolve when the Executive Governing Body is fully populated. The Executive Governing Body will be the decision-making body of RCHC. It will oversee the contracts between RCHC and its PPS partners and distribute funds according to the distribution formula developed by the Financial Governance Committee and approved by the Executive Governing Body.

The Operations Committee will have responsibility for the day-to-day operations and will include representatives from the 3 original members of the Steering Committee, Refuah, Ezras Choilim Health Center, and Good Samaritan Hospital. The Project Management Office will report to the Operations Committee, which reports to the Executive Governing Body. The Project Management Office will have a lean staff, consistent with how Refuah and Ezras Choilim operate as FQHCs. Staff will include a Chief Executive Officer, Medical Director, Director of Program Information & Innovation and a Compliance Officer. The Operations Committee will select the staff of the Project Management Office.

The governance structure focuses on the fiduciary responsibility of Refuah and the important roles played by a FQHC partner, Ezras Choilim, and the lead hospital partner, Good Samaritan. Ezras Choilim has agreed to assist Refuah in assuming financial risk of RCHC's operation. Good Samaritan brings the experience of being a hospital member of an already existing integrated delivery system model (Bon Secours Charity Health System).

The Steering Committee determined that a representative of each PPS partner category was necessary to serve on the Executive Governing Body. The PPS partner categories include: behavioral health, developmental disability, long-term care, home care, workforce/labor, clinicians, Federally Qualified Health Centers, and community organizations. The inclusion of a representative on the Executive Governing Body from each of the PPS partner categories will ensure maximum input and participation by the universe of PPS partners at the highest level of governance.

Each of the Financial, Clinical, and Data/IT Governance Committees will provide the Operations Committee with information for the Operations Committee to fulfill its responsibility to oversee the daily operation of RCHC. Each Committee will directly report to the Executive Governing Body. There will be broad-based representation on all Governance Committees and the Compliance Committee, such that the expertise of each of the categories of PPS partners are utilized. Each of the Governance Committees and the Compliance Committee will have 5-10 members. Current participants on the Financial Work Group and Clinical Work Group will be eligible to continue as members of the Financial Governance Committee and Clinical Governance Committee, respectively. PPS partners will be eligible for

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representation on all Committees and Work Groups. Specific Committee Charters will be adopted by each Committee and approved by the Executive Governing Body by February 1, 2015. The composition of all Committees, including the final number of members and the selection of Chairs of each Committee, will be determined jointly by Refuah and Ezras Choilim by February 1, 2015.

***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 Steering Committee approved the Projects recommended by the Clinical Governance Work Group and thoroughly vetted them with PPS partners at PAC meetings. The Clinical Governance Committee will be the watchdog for implementation of the Projects. The Clinical Governance Committee is in charge of developing metrics, clinical and management processes and is the monitor of PPS partners being held accountable for quality outcomes. The Clinical Governance Committee will have the authority to set up specific Work Groups as needed to implement the Projects. Members of the Clinical Governance Committee will include representatives of PPS partners who have experience and expertise in care management and population health. It will adopt and implement a dashboard for use in monitoring accountability of the PPS partners. All activities of the Clinical Governance Committee, including monitoring of clinical outcomes, will be overseen by the Operating Committee and Executive Governing Committee to ensure continued compliance with the PPS goals and objectives. The Governance Committees, Operations Committee, and the Executive Governing Body will work together in the event PPS partners need counseling to assist them in realizing clinical outcomes. The Clinical Governance Committee will develop action plans for PPS partners in need of assistance with Project clinical implementation, work in concert with the Financial Governance Committee regarding financial needs of the PPS partners, and monitor the continued financial viability of the PPS Partners. The process to be implemented by RCHC to rectify lower performing partners, the potential sanctions to be assessed and the PPS partner removal process is discussed in the Oversight section.

***Structure 4:**

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

The Collaborative Contracting Model adopted for RCHC is most suited to the limited number of PPS partners involved in the implementation of the Projects. There will be extensive input to, and participation on, all Committees and Work Groups by a significant number of PPS partners. As value-based contracting becomes the predominant method of managed care contracting, RCHC will establish a specific Committee to review contracting options. As needed, the Committees will be vested with the authority to create Work Groups for contract negotiation and implementation. In the event that the Executive Governing Body believes that a higher degree of integration in the PPS is needed, it will explore moving towards a Delegated Authority model. The Executive Governing Body will consult with the PAC and RCHC legal and financial advisors regarding the creation of a new legal entity to implement the Delegated Authority model. RCHC may form or become a participant in a Medicaid ACO or IPA during the 5 years of DSRIP.

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 Governing Body is in its formation stage. The representatives listed below have been selected to serve as members of the Executive Governing Body. The remaining members will be selected no later than February 1, 2015. Certain of the members of the Executive Governing Body will be the officers of RCHC and Chairs of Committees. Job descriptions for the officers will be presented to the Executive Governing Board for approval no later than February 1, 2015.

Refuah – Lead Entity: Chanie Sternberg, Chair
Ezras Choilim: Joel Mittelman, Vice-Chair/Treasurer
Good Samaritan: Deborah Marshall, Secretary
Clinicians: Sanjiv Shah, MD, Member

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FQHC: Anne Nolon, Member
Behavioral Health: In development
Developmental Disability: In development
Long-Term Care: In development
Home Care: In development
Workforce/Labor: In development
Community Organizations: In development

***Process 2:**

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

As founding members of the Steering Committee, Refuah, Ezras Choilim, and Good Samaritan selected their own representatives to the Executive Governing Body. The selection of additional members of the Executive Governing Body from the PPS partner categories will be made jointly by Refuah and Ezras Choilim and approved by the Steering Committee no later than February 1, 2015. Each of the selected members will have extensive experience in care management, workforce strategy, and/or population health. Many of the representatives will have been participants at PAC meetings and/or active contributors in the formation of RCHC. The Executive Governing Body will establish and approve a position description for members of the Executive Governing Body, detailing their duties and fiduciary responsibilities to RCHC. In addition, the Executive Governing Body will establish criteria for removal of any Executive Governing Body member (other than those selected by Refuah, Ezras Choilim, and Good Samaritan) for failure to fulfill the agreed-upon duties and responsibilities. Refuah and Ezras Choilim shall make the final decision on removal of such member, after receiving a recommendation from the Executive Governing Body. Refuah and Ezras Choilim will meet with the PPS partner representative prior to a removal decision to determine if corrective action could be agreed upon to address concerns raised in the recommendation from the Executive Governing Body. Continued participation of the original members of the Executive Governing Body for their appointed term of 3 years is a goal of RCHC, as such continuity and historical knowledge will provide for efficient and productive operations of the Executive Governing Body.

***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.

Each PPS partner category, including community organizations, will have a representative on the Executive Governing Body. Each PPS partner category will be encouraged to have a representative participate on the Committees and their Work Groups, when developed. Most of the PPS partners have participated in PAC meetings and all PPS partners will be encouraged to attend all future PAC meetings. Having such a limited number of PPS partners enables RCHC to gain the expertise and active participation of all PPS partners across the continuum of care.

***Process 4:**

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

RCHC is fortunate to have a number of community-based organizations as PPS partners across Rockland and Orange Counties. The community-based organizations are integral to community support of RCHC. Arrangements will be sought with certain of these organizations to assist RCHC in the dissemination of RCHC activities to the community and providing support to implement RCHC's cultural competency and health literary efforts. RCHC strives to develop a PPS that promotes the values of cultural inclusion and competence and ensures that providers and staff have the knowledge and skills to deliver services that are respectful of and responsive to the health beliefs, practices, and cultural and linguistic needs of diverse patients. The participation of the community-based organizations will be integral to the attainment of these goals.

***Process 5:**

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

The Executive Governing Body will have 11 members with weighted voting totaling 21 votes. Refuah will have 1 representative and 6 votes. Ezras Choilim will have 1 representative and 5 votes. Good Samaritan will have 1 representative and 2 votes. These 3 Steering Committee members will have a total of 3 members and 13 votes. The PPS partner categories will have 8 members and 8 votes. Each representative on the Executive Governing Body will serve a 3-year term and may be reappointed.

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Except as set forth below, all actions taken by the Executive Governing Body require a majority vote of a quorum of its members. A quorum for meetings of the Executive Governing Body will be a majority of the 11 members present in person or participating by telephone or other electronic means. The representatives from Refuah, Ezras Choilim, and Good Samaritan, or their designees, must be present at each Executive Governing Body meeting for action to be taken.

Any action to be taken related to the following matters will require the affirmative vote of representatives of Refuah and Ezras Choilim; all financial decisions, including those relating to IT and infrastructure; any changes to the Governance Structure; Merger/Termination/Dissolution decision; adding new PPS partners, whether providers or non-providers; removing any PPS partners, whether providers or non-providers, in accordance with RCHC's partner removal process; any changes to Project selection; and form of contracts with various types of PPS partners/providers/non-providers.

***Process 6:**

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

The voting process outlined above has been structured to minimize conflict through the requirement of a quorum at Executive Governing Body meetings. The weighted voting structure ensures the required oversight by Refuah as the Lead Agency with fiduciary responsibility to the State and provides appropriate input by Ezras Choilim as a financially responsible PPS partner. All Committees will have a quorum requirement and decision making will be a collaborative consensus-based approach. Consensus means that the agreement of at least a majority of the Committee members is needed. In the event that a conflict exists at the Committee level, the Committee shall make a report to the Executive Governing Body containing recommendations on how to resolve the conflict. Conflicts will be brought to the Executive Governing Body for resolution. Resolution of a conflict will be determined by the majority vote of the members of the Executive Governing Body.

***Process 7:**

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

The minutes of the Executive Governing Body will be distributed to its members. As part of the communications program to be developed by the PPS, the minutes will be posted on the RCHC website in a PPS partner-only page or on a section that only PPS partners can access. The Executive Governing Body will make a determination if a subject matter coming before it requires an Executive Session. If an Executive Session is held, no minutes will be taken of those proceedings consistent with Roberts Rules of Order. All representatives on the Executive Governing Body will be expected to attend Executive Governing Body and PAC meetings to maintain communication and collaboration with PAC members. Actions taken by the Executive Governing Board will be posted on a PPS partner-only link on the RCHC website.

***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 communications program will be developed by RCHC to inform Medicaid members, PPS partners, and the communities served by the PPS of the progress of RCHC Projects. Community outreach will be a key component of the communications program. Communications will be frequent and will take the form of Town Hall meetings, website postings, and email and regular mail to the stakeholders. There will be alerts, as needed, sent to all stakeholders of critical and immediate actions taken by RCHC on implementation of the Projects.

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.

On July 24, 2014 the Refuah Community Health Collaborative (RCHC) Steering Committee approved a stakeholder engagement and communication plan, which included the formation of the PAC. To form the PAC and ensure broad representation, RCHC asked all partners for representatives. RCHC gathered information from partners and assessed membership requirements for union, worker, and

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managerial staff. RCHC contacted all partners with details on the required and optional representatives from each organization and requested that they select PAC representatives. RCHC's PAC comprises 108 representatives, including 71 managerial, 33 worker, 2 union, and 2 consumer representatives. PAC members represent the full continuum of care, including primary care, acute care, behavioral health, substance abuse, long-term care, development disabilities, home care, local departments of health and mental health, and pharmacies, as well as labor, community-based service organizations, and consumers.

On 8/7, RCHC hosted a webinar for partners that presented on the fundamentals of DSRIP and the RCHC planning process so that all partners could provide input at the onset and be prepared to participate in the PPS and PAC. The PAC kick-off meeting was held on 9/10 and then meetings were held monthly thereafter.

***Committee 2:**

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

The PAC's role is to provide input on the PPS throughout the DSRIP period, including on RCHC's organizational structure and governance; the CNA; project selection/design; and workforce, financial, sustainability, and implementation plans. PAC members have and will continue to provide input through in-person meetings, webinars, workgroups/committees, discussion sessions, RCHC's website, emails and calls.

During the next phase, the PAC will meet monthly to provide input on implementation plans and PPS budget. PAC members will participate on workforce and clinical workgroups to help develop implementation plans, the workforce assessment and plan, and budgets.

During implementation, the PAC will meet at least quarterly to provide input on implementation. PAC members will participate in the following Governance Committees: Financial, Clinical, Data/IT, Operational, and Compliance. They also will participate in workgroups under the Financial, Clinical, and Data/IT Governance Committees.

***Committee 3:**

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

PAC members provided input on the development of the PPS organizational structure and the CNA at monthly PAC meetings. RCHC presented the governance structure and rationale at PAC meetings, which were met with approval. Based on PAC feedback, the structure includes representation by provider type. RCHC also posted meeting materials on its website for PAC members to review and provide input.

During a public comment period, all PAC members were asked to review findings on the Mid-Hudson region CNA via a link on the RCHC website. At a PAC meeting, members requested that all 3 PPSs coordinate getting feedback on the CNA through a single point of contact. RCHC also conducted a survey that requested feedback on potential roles each partner could play within the PPS and used the findings in the design of the PPS. RCHC asked partners to indicate if and how they wanted to be involved with governance and used that feedback to select members of the Executive Body and committees.

***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.

RCHC developed the PAC to ensure that it represents all PPS providers and community organizations. RCHC surveyed partners via email and follow-up phone calls to assess the number of employees; which, if any, unions represent their workers; and if each organization had different service lines for which they would like additional PAC representation. Based on this, RCHC determined membership requirements for union, worker, and managerial staff according to State guidelines. RCHC contacted all partners with details on the required and optional representatives and requested that they select PAC representatives. RCHC invited the six unions representing employees at PPS partners to select a PAC representative. RCHC also invited two consumers from the Boards of two health providers to join the PAC. RCHC's PAC comprises 108 representatives, including 71 managerial, 33 worker, 2 union, and 2 consumer representatives and represents the full continuum of care in Rockland and Orange Counties.

Section 2.4 – Compliance:

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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.

RCHC will retain the services of an independent Compliance Officer who will not be related in any way to the Lead Entity or any of the PPS Partners. The Compliance Officer will be part of the Project Management Office and report to the Operations Committee and ultimately to the Executive Governing Body. The Compliance Officer has the principal authority and responsibility for the development, implementation, oversight, and evaluation of all aspects of the RCHC Compliance Program. The Compliance Officer is authorized to investigate all incidences of suspected illegal or unethical conduct to determine the necessary facts. The Compliance Officer will have all the duties and responsibilities that are ordinarily delegated to Corporate Compliance Officers. A separate Chair of the Compliance Committee will be selected from the members of the Executive Governing Body.

***Compliance 2:**
Describe the mechanisms for identifying and addressing compliance problems related to the PPS' operations and performance.

The Compliance Plan will contain a policy that will enable any person who has knowledge of or, in good faith, suspects any wrongdoing related to the operation of RCHC to report it internally so that an investigation can be conducted and appropriate action taken. Retaliation or reprisal against anyone for such a report will be strictly prohibited. Anyone who becomes aware of or in good faith suspects wrongdoing should report it to his/her supervisor and/or the Compliance Officer. The individual making the report may do so by reporting the concern in writing or by using the Compliance hotline or dropbox. Self-reporting will be encouraged. Upon a report of wrongdoing, the Compliance Officer will conduct an investigation into the allegations to determine the nature, scope and duration of wrongdoing, if any. If the charges are substantiated, then the Compliance Officer will develop a plan for corrective action and notify the Compliance Committee, the Operations Committee and the Executive Governing Body. The Compliance Officer will annually conduct an audit of RCHC operations to ascertain compliance problems and concerns.

***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.

To ensure that all PPS partners are familiar with the Compliance Plan, the Compliance Officer will have the responsibility for developing and conducting continuing training and education regarding the Compliance Plan, which will be mandatory for all PPS partners. These training programs have not yet been developed as RCHC is still in the process of retaining the Compliance Officer. The training programs will stress and reinforce the fact that strict compliance with the law and the Compliance Plan is a condition of the participating provider agreement with each PPS partner. In addition to the distribution of any updates to the Compliance Plan, RCHC shall hold annual educational seminars to raise the level of awareness regarding compliance in the healthcare industry and repercussions from noncompliance. The Compliance Officer will disseminate relevant bulletins, memorandum and other pertinent materials from governmental and other agencies to PPS partners to familiarize themselves with pertinent rules and regulations changes.

***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 Program will include a policy by which PPS partners, community members, Medicaid beneficiaries, and uninsured members attributed to the PPS will understand how to file a compliance complaint and what should be included in such complaint. The Compliance Officer will be in charge of implementing this policy and disseminating the necessary information on how to file a compliance complaint. Methods of filing a complaint shall include filing of a complaint in writing to the Compliance Officer or by using the Compliance hotline or dropbox. Complaints may be filed anonymously. Written materials on this program will be distributed by the Compliance Officer to each PPS Partner for distribution to its employees. Instructions on how to file a compliance complaint will also be listed on the Compliance section of the RCHC website.

Section 2.5 - PPS Financial Organizational Structure:

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

***Organization 1:**
Please provide a description of the processes that will be implemented to support the financial success of the PPS and the decision making of the PPS' governance structure.

The financial success of Refuah Community Health Collaborative (RCHC) will be grounded in the governance structure and strong internal controls and reporting processes. The RCHC Executive Governing Body will be supported by the Finance Governance Committee, which will have oversight responsibility for all financial matters and report to the Executive Governing Body on a monthly basis. The Committee will be supported by finance staff within the Project Management Office. This Committee's responsibilities will be detailed in the committee charter and will include:
-Develop financial policies and procedures for approval by the Executive Governing Body by April 1, 2015
-Continue development and monitoring of DSRIP funds
-Monitor financial and operating performance of the PPS network as well as individual partners to assist the Executive Governing Body with decision-making functions
-Prepare budgetary framework to support DSRIP program and ensure sustainability of the PPS network
-Create recommendations for value-based payment options and work with Medicaid MCOs on their implementation
-Establish executive compensation practices consistent with IRS regulation and Executive Order #38

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

The Finance Work Group is currently working on the development of finance policies and procedures over the management and distribution of the DSRIP program funding. Finance practices will address strong internal controls and accurate financial reporting as well as protocols over the administration of DSRIP grant funds consistent with Federal grant requirements. A DSRIP Program Manager will be hired into the Project Management Office to perform the finance functions. The following finance functions are currently under development:
- Annual budget process
- Controls over the disbursement of funds for authorized purposes and spending limits
- Monthly reporting of actual performance versus budget
- Definition of performance metrics/milestones for Partner organizations to support incentive payment allocation
- Management/monitoring of partner performance and funds flow
- DSRIP performance reporting requirements
- Contract reviews of partners and vendors for compliance with legal and DSRIP funding requirements as well as evaluating performance

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

RCHC will use an independent external audit firm to audit compliance of the finance functions related to DSRIP on a regular basis. The audit plan and frequency are under development and will be presented to the Executive Governing Body before April 1, 2015; the audit is intended to be consistent with the program specific audit requirements contained in "Government Auditing Standards". The firm that is selected must be familiar with the DSRIP program as well as the compliance requirements of the Office of the Medicaid Inspector General (OMIG).

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

A PPS-specific compliance program is under development, consistent with OMIG's requirements and New York State Social Services Law 363-d, for approval by the PPS Executive Governing Body with an expected completion date of April 1, 2015. At a minimum, the PPS's Corporate Compliance Plan will include the establishment of a committee responsible for the receipt/resolution of regular compliance reports and reporting to the PPS Executive Governing Body as well as individual PPS providers, as deemed appropriate. A DSRIP Compliance Officer will be responsible for auditing PPS Partners on program performance and reporting to ensure that providers are accurately reporting DSRIP project metrics/milestones. A prospective audit process will be implemented for provider organizations that have been identified for more focused reviews prior to reporting to DOH.

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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.

RCHC has the obligation to continually oversee, discipline, or terminate any PPS partner's ("Partner") participation in RCHC for performance issues, including but not limited to, quality medical care, compliance issues, financial instability, or lack of collaboration in meeting Project goals and outcomes. The Project Management Office (PMO) will assist the Committees in monitoring PPS partner performance on a regular basis through data tools and metrics developed by the applicable Committees and adopted by the Executive Governing Body (EGB). The PMO will periodically report its findings to the Operations Committee (OC) and other applicable Committees and the EGB.

The PMO will refer all potential quality concerns to the OC for review. If the quality concern is related to a Partner's clinical performance, the OC will refer the concern to the Clinical Governance Committee. This Committee will be responsible for obtaining feedback from Medicaid beneficiaries as part of its review of the PPS partners' clinical performance. If the quality concern is related to a PPS partner's financial performance, the concern will be referred by the OC to the Financial Governance Committee.

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

The Clinical Governance and Financial Governance Committees will provide the Operations Committee and the Executive Governing Body with periodic summary reports (no less than quarterly) on a PPS partner's performance. The Clinical Governance and Financial Governance Committees will provide detailed reports on lower performing PPS partners to the Operations Committee and Executive Governing Body as needed. The Operations Committee, with input from the applicable Committee, will be tasked with the responsibility of tailoring a corrective action plan for a lower performing PPS partner to improve their performance. The corrective action plan will be approved by the applicable Committee and the Executive Governing Body. The Chair of the Clinical Governance or Financial Governance Committee, as applicable, will meet with the PPS partner to explain the corrective action plan and to document the agreement of the PPS partner to engage in such plan.

***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.

When a clinical quality or financial viability concern subject to a corrective action plan is not rectified by a PPS partner, it will be investigated by either the Clinical Governance Committee or Financial Governance Committee. The applicable Committee will notify the PPS partner and request a written response, along with any supporting documentation, within a specified period of time. The Committee shall review all documentation alleging violations or deficiencies in the PPS partner's clinical or financial performance and the failure to remedy poor performance. The Committee will meet promptly with the PPS partner to discuss documentation which the Committee reasonably believes to have merit. The Committee shall place a written account of the meeting, including pertinent discussion, problems identified, and plans for next steps in the PPS partner's file.

The Committee will promptly send its findings and recommendations to the Executive Governing Body, which shall be responsible for issuing a final determination (containing any applicable sanctions) within a reasonable time period after receiving the findings and recommendations. Notification of action taken and sanctions assessed on the PPS partner will be communicated in writing by the Executive Governing Body.

The following sanctions may be adopted by the Executive Governing Body in the discipline of PPS partners (sanctions may be progressive and/or combined): informal resolution; oral reprimand; written reprimand; financial penalty; and probation with the length of time specified. Unless a PPS partner terminates operations or there is some other extreme circumstance determined by the Executive Governing Body to require removal of the PPS partner, RCHC will not be able to remove the PPS partner or not renew its participating provider agreement until the mid-point assessment of DSRIP Year 3. Any changes in the PPS partner's participation in RCHC at the DSRIP mid-point

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assessment (including non-renewal or removal) will be submitted to DOH and CMS for review.

***Oversight 4:**

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

As part of its continued monitoring process of PPS partners, the Clinical Governance Committee will gather information regarding a PPS partner's clinical performance. Inquiries will be made of Medicaid beneficiaries and their advocates regarding performance of PPS partners and included in the PPS partners' file. Feedback will come from patient satisfaction scores and specific comments and, if applicable, any complaints or grievances filed by patients or their advocates. The participating provider agreement with each PPS partner will require such PPS partner to notify the Operations Committee of any complaints or grievances received from Medicaid beneficiaries and their advocates. This information will be included in the periodic reports provided by the Clinical Governance Committee to the Operations Committee and Executive Governing Committee.

***Oversight 5:**

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

The Executive Governing Body will authorize the Project Management Office to communicate with applicable Medicaid beneficiaries regarding the non-renewal or termination of a PPS partner's participating provider agreement and make such arrangements as are necessary to continue the medical care of the affected Medicaid beneficiaries. Such communication shall be in writing followed up by a personal conversation or meeting with the affected Medicaid beneficiaries. Confirmation of the transition of care for Medicaid beneficiaries will be done in writing.

Section 2.7 - Domain 1 – Governance Milestones:

Description:

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

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

☑ Please Check here to acknowledge the milestones information above

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SECTION 3 – COMMUNITY NEEDS ASSESSMENT:

Section 3.0 – Community Needs Assessment:

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

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

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

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

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

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

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

This section is broken into the following subsections:

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

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

Scoring Process:

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

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

Section 3.1 – Overview on the Completion of the CNA:

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

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

The 3 Mid-Hudson PPSs collaborated on a regional CNA led by Westchester Medical Center. The CNA aligns with DOH guidance and analyzed existing health, utilization, socio-demographic, and built environment data and collected new quantitative and qualitative data.

Geographic information science and spatial analyses were used to identify population health issues (e.g., access to care, socio-economic data, and patterns of disease burden by population and region). The CNA isolated "hot and cold spots" (i.e., statistical clusters of zip codes with values higher or lower than would be expected) using variables from a range of sources (e.g., ACS, Vital Statistics, DSRIP dashboards) related to outcomes and socio-demographic determinants (e.g., poverty, English language proficiency, race/ethnicity, employment, physical activity). Select narrative and community profiles were developed for "hot spot" zip codes and mapped interactively using Google Earth to guide project selection and design.

The CNA included a survey of Hudson Valley consumers. The survey conformed to health literacy standards and was available online and on paper in five languages prevalent in the Hudson Valley: English, Spanish, Portuguese, French Creole, and Yiddish. As of 12/1, there were 4,700 responses representative of the overall region.

The CNA included 3 consumer groups to discuss barriers to access and health behaviors; 7 behavioral health focus groups with over 60 participants from over 30 organizations; a focus group with ED providers and staff; and key informant interviews with experts on vulnerable populations, including people with developmental disabilities and incarcerated/formerly incarcerated residents. 45 providers responded to surveys on HIT, cultural competence, and health literacy.

Input was collected at over 60 meetings and webinars. Prevalence maps, workbooks and survey results were available via a link on the PPS website and input was obtained during a public comment period.

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

The needs assessment was designed within a geographic information science (GISc) framework. GISc and spatial analyses were used to identify population-based health issues. Detailed-level SPARCS data provided by academic colleagues at Iona College, along with Medicaid claims data from the Health.NY.Gov dashboard and Census information were mapped to identify community needs by prevalence indicators for major diagnostic categories. Using SPARCS data we identified patients' ED visits, hospitalizations, and re-admissions and analyzed trends to identify negative quality indicators. All 3 PPSs in the region worked with county health departments to coordinate local surveys about capabilities (e.g., health IT, Community Resources, Healthcare Resources, consumer/resident survey) to supplement what was available on secondary websites.

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The CNA isolated "hot and cold spots" (statistical clusters of zip codes with values higher or lower than expected). This approach was expanded to include variables from a range of other sources (e.g., ACS, Vital Statistics, Salient Data Portal, DSRIP dashboards) related to outcomes and socio-demographic determinants (e.g., poverty, English-speaking ability, race/ethnicity, employment, physical activity). Narrative and community profiles were developed for "hot spot" zip codes and mapped using Google Earth to help maximize the efficiency of proposed interventions.

Qualitative information was gathered through 3 consumer groups; 7 behavioral health focus groups with over 60 participants from over 30 organizations; a focus group with ED providers and staff; and key informant interviews with experts on vulnerable populations, including people with developmental disabilities and incarcerated/formerly incarcerated residents. The CNA also included a consumer survey (with 4,700 responses as of 12/1/14). 45 providers responded to surveys on HIT, cultural competence and health literacy. A detailed list of data sources is in the attached CNA report.

Section 3.2 – Healthcare Provider Infrastructure:

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

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

#	Provider Type	Number of Providers (Community)	Number of Providers (PPS Network)
1	Hospitals	13	8
2	Ambulatory surgical centers	47	0
3	Urgent care centers	5	0
4	Health Homes	4	2
5	Federally qualified health centers	26	14
6	Primary care providers including private, clinics, hospital based including residency programs	910	234
7	Specialty medical providers including private, clinics, hospital based including residency programs	5368	1439
8	Dental providers including public and private	11	7
9	Rehabilitative services including physical therapy, occupational therapy, and speech therapy, inpatient and community based	10	1
10	Behavioral health resources (including future 1915i providers)	226	160
11	Specialty medical programs such as eating disorders program, autism spectrum early	1	0
12	diagnosis/early intervention	0	0
13	Skilled nursing homes, assisted living facilities	25	9
14	Home care services	47	12
15	Laboratory and radiology services including home care and community access	9	1
16	Specialty developmental disability services	38	10
17	Specialty services providers such as vision care and DME	154	12
18	Pharmacies	107	12
19	Local Health Departments	10	10
20	Managed care organizations	5	5
21	Foster Children Agencies	1	0
22	Area Health Education Centers (AHECs)	1	0

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

***Infrastructure 2:**

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

Gaps in providers exist most in the coordination between existing providers, the types of providers engaged in the primary care setting, and the communication with patients across all providers.

As detailed in the attached CNA report, a hot-spotting analysis identified 10 hot spots of need across the Mid-Hudson region and 3 are located in Refuah Community Health Collaborative's (RCHC) service communities of Newburgh, Middletown, and Spring Valley. These areas have the largest concentrations of Medicaid beneficiaries with chronic conditions and behavioral health issues and contain high rates of poverty and unemployment and low rates of education. Although these areas contain a high density of the region's providers, there is a need for increased support for patients in better accessing care and available resources and better population management. High-need populations would benefit from increased care management—something that patients noted is currently lacking in all provider settings.

Cost is a large concern for the high-need populations in the region. Consumers noted the community lacked integrated services. A need to access care at multiple locations leads to multiple co-pays, additional transportation costs, and longer waiting periods. The Rockland County Health Department administers several clinics at its main site in Pomona (Dental, Foreign Travel Immunization, Tuberculosis, Sexually Transmitted Disease (STD) Infectious Disease, Chest, Family Planning Services, Adult Immunization, and Well Child); however, all clinics except the STD clinic require a scheduled appointment. Additionally, the clinics operate separately and none provide comprehensive primary care services through one appointment, increasing the time and resources necessary to access these low/no cost services.

Only 5 urgent care centers were identified across the region, limiting access to care after hours. Of those surveyed across the Mid-Hudson region that received care in an emergency room in the past year, 19% attributed their visit to their doctor's office being closed.

All FQHCs in the area provide dental care services on a sliding fee scale; however, 28% of patients surveyed noted that they had not had a routine dental check-up in the past 12 months, and the most common reason given was cost. Additional capacity and/or increased community awareness of existing services may be necessary to reach this population.

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	25	4
2	Food banks, community gardens, farmer's markets	39	1
3	Clothing, furniture banks	7	0
4	Specialty educational programs for special needs children (children with intellectual or developmental disabilities or behavioral challenges)	17	4
5	Community outreach agencies	67	7
6	Transportation services	1	1

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#	Resource Type	Number of Resources (Community)	Number of Resources (PPS Network)
7	Religious service organizations	27	2
8	Not for profit health and welfare agencies	50	14
9	Specialty community-based and clinical services for individuals with intellectual or developmental disabilities	11	5
10	Peer and Family Mental Health Advocacy Organizations	22	9
11	Self-advocacy and family support organizations and programs for individuals with disabilities	5	1
12	Youth development programs	29	4
13	Libraries with open access computers	34	0
14	Community service organizations	35	2
15	Education	137	1
16	Local public health programs	7	7
17	Local governmental social service programs	3	3
18	Community based health education programs including for health professions/students	25	4
19	Family Support and training	42	6
20	NAMI	2	1
21	Individual Employment Support Services	4	0
22	Peer Supports (Recovery Coaches)	2	1
23	Alternatives to Incarceration	0	0
24	Ryan White Programs	0	0
25	HIV Prevention/Outreach and Social Service Programs	11	3

***Resources 2:**

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

Although many types of community resources are found within our region, transportation issues prevent our patients from accessing available services. Public transportation across the region is limited or non-existent. Many available public transportation options are in place to assist in commutes toward New York City but not for localized transit. Patients noted accessing care required multiple transfers or involved limited schedules leading to long travel and waiting times. Additionally, large families are prevalent in the service area and families often need to travel with many children. This creates barriers not only to accessing health care but also to accessing all available community resources.

The service area population is incredibly diverse and includes large religious communities and growing numbers of Haitian and Hispanic immigrants (with 29% of households speaking a language other than English at home). Patients across racial and ethnic backgrounds noted a lack of peers/advocates within the community to provide information on health resources and health management. The Center for Health Care Strategies estimates that large numbers of minorities and immigrants are estimated to have health literacy problems, including 50% of Hispanics, 40% of African Americans, and 33% of Asians. The Refuah Community Health Collaborative (RCHC) will contract with community-based organizations and hire community health workers and peer navigators to assist in accessing appropriate health resources and educational information.

Patients and providers also noted a need for additional resources to educate families, advocates, and the general community on behavioral health issues to reduce the fear and stigma surrounding behavioral health issues and to inform the larger community on how to access the range of services available to assist in behavioral health crises. RCHC will provide community health workers and peer navigators to provide that education.

Given the high birth rates in the service area and that maternal/child (e.g., vaginal or cesarean deliveries, newborn with other problem) are among the top 20 Medicaid inpatient discharges in the service area, several RCH partners also will develop a birthing center as an

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alternative to hospital deliveries. The birthing center would be an important part of the Integrated Delivery System by filling a critical gap in the area, reducing hospital costs, and being a resource for navigators to connect with families in need of other care and services.

Section 3.4 – Community Demographic:

Description:
Demographic data is important to understanding the full array of factors contributing to disease and health. Please provide detailed demographic information, including:

***Demographics 1:**
Age statistics of the population:

The service area comprises two counties, Rockland and Orange, which are home to 685,000 residents (3.5% of the statewide population), evenly divided by males and females. The median age in the service area is 36.7 years, slightly younger than the statewide median of 38. Approximately 12.2% of the population comprises seniors age 65 and older, compared to 13.6% of the population statewide. Just over 30% of the population is under the age of 20, compared to 25% statewide. Certain communities exhibit significantly younger median ages than the area as a whole.

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

Two-thirds of the population is White, 10% is African American, and 17% is Hispanic. There are several large, growing, immigrant communities, including Hispanic and Haitian communities and one of the largest Hasidic Jewish communities in the U.S. Nearly one-third of the population of Spring Valley is Haitian, giving it one of the highest concentrations of Haitians in the U.S. Rockland's Haitian population has grown by 15.4% from 2009 to 2012, and its Hispanic population grew by 26.5% in the same period. 71% of households in the area speak only English at home, compared to the NYS rate of 70%. There are significant variations within the area, with 77% of Orange residents speaking only English compared to 63% in Rockland. Spanish, French and Spanish Creole, Portuguese and Yiddish are dominant languages in high-need areas. With the growing immigrant population in the area, health literacy is a significant barrier, especially in communities where English is not the main language.

***Demographics 3:**
Income levels:

Median household income ranges from $68,329 in Orange County to $84,752 in Rockland County. 7% of Rockland County and 9% of Orange County households had income below $15,000 per year. With respect to health insurance coverage, approximately 30% of the population has public health insurance and an estimated 10% are currently uninsured. The remaining had some form of private coverage. There are 154,000 Medicaid-covered lives, representing 3% of the total Medicaid enrollees in New York State (7% of Medicaid enrollees excluding NYC).

***Demographics 4:**
Poverty levels:

Approximately 12% of the population is living at or below the poverty level, while 25% of the population is considered low-income (below 200% FPL). An estimated 19% of children are living below the poverty level.

***Demographics 5:**
Disability levels:

Among the non-institutionalized population, approximately 10% of residents in the region are living with a disability, a rate comparable to the statewide rate of 11%. The region is primarily suburban, and lack of transportation presents a significant barrier to care in these communities, especially for the disabled. Low-income families often cannot afford cars or taxis, which limits access to care. There is limited or no public transportation in the service area.

***Demographics 6:**
Education levels:

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On average 46% of adults have completed high school or college, a rate equivalent to the statewide average. Completion rates vary by county, however, with Rockland County having a much higher rate of college completion (23% of adults compared to 17% in Orange County).

***Demographics 7:**

Employment levels:

The unemployment rate for those 16 years and older ranges from 7.5 % to 7.9%, indicating that the region has fared slightly better than the state as a whole (unemployment rate 8.7%) as it continues to emerge from the recession. Primary occupation categories include management, business, sciences, art, and sales.

***Demographics 8:**

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

There are three psychiatric centers that provide comprehensive programs for those who require institutionalized care in the region, including one forensic center; one psychiatric hospital exclusively for children and adolescents; and one for adults 18 and older with serious mental illness. There is one state prison facility (Otisville) in the region. The number of homeless applicants/cases in Orange County increased by nearly 45% from 1,733 in 2008 to the 2,518 homeless persons that received emergency housing assistance in 2012. Similar estimates were not available for Rockland County.

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

As necessary, please include relevant attachments supporting the findings.

File Name	Upload Date	Description
20_SEC034_Project 3.a.iii,Question 1c,RefuahCommunityHealthCollaborative.docx	12/21/2014 09:43:37 PM	RCHC response to Project 3.a.iii, Question 1c
20_SEC034_Project 2.a.ii,Question 1,RefuahCommunityHealthCollaborative.docx	12/21/2014 09:42:47 PM	RCHC responses to Project 2.a.ii, Question 1

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:

Based on Vital Statistics data, the leading causes of death are heart disease, cancer, chronic lower respiratory diseases (CLRD), unintentional injury and stroke, with cancer and heart disease accounting for roughly half of deaths annually. Among minority populations diabetes and pneumonia replace CLRD and stroke. The top causes of premature death are cancer, heart disease, unintentional injury, CLRD, and septicemia or suicide. On average, the ratios of Black non-Hispanics and Hispanics to White non-Hispanics percentage of premature death for the Mid-Hudson region are 1.99 and 2.29, respectively, indicating significant health disparities.

***Challenges 2:**

Leading causes of hospitalization and preventable hospitalizations by demographic groupings:

SPARCS data (2012) indicate that among Medicaid inpatient discharges, the top 20 fall into 5 categories maternal/child (e.g., vaginal or cesarean deliveries, newborn with other problem), behavioral health/substance abuse (e.g., alcohol or drug abuse and dependence), infection (e.g., septicemia and disseminated infections, cellulitis), digestive (e.g., cholecystectomy), and respiratory (pneumonia, COPD). Age-adjusted (2012) preventable hospitalizations across all payers were below the 2017 objective of 133.3 per 10,000, with rates ranging from 93.8 (Rockland) to 124.3 (Orange). In both counties, preventable hospitalization rates experienced statistically significant improvement between 2011 and 2012.

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***Challenges 3:**

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

Orange County's hospitalization rate for adult short-term diabetes complications (5.9 per 10,000) exceeds the Prevention Agenda (PA) target (4.86 per 10,000), and hospitalization rates for heart attack (18.1 per 10,000) exceed both the PA target (14.0) and statewide rate (15.2). Medicaid hospitalization rates in Orange County for multiple PQIs (including short-term diabetes complications, hypertension and all respiratory) exceed expected rates, often by a large margin. The region has high rates of several risk factors that contribute to Ambulatory Care Sensitive Conditions and overall poor health status. Very high adult obesity rates are of particular concern, with 31.8% of Orange adults obese. The adult smoking rate in Orange (15.7%) exceeds both the PA target (15%) and statewide rate (15.6%). In Rockland, 16.9% of children and adolescents are obese, a rate in excess of the PA 2017 target of 16.7%. Lack of physical activity is also a risk factor for the service area. Nearly 23.7% of adults in Orange and 27.6% of adults in Rockland report having no leisure time physical activity, compared to a statewide rate (excluding NYC) of 21.1%.

***Challenges 4:**

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

Prevalence data are based on BRFSS (2008-2009) and SPARCS (2008-2013); count data are from the Medicaid Chronic Conditions file, 2012. The age-adjusted cardiovascular disease prevalence rate is 5.5% in Rockland and 6.3% in Orange, under the statewide rate (7.2%). However, CVD-related ED visits show a large hot spot in Middletown as well as smaller clusters in Rockland. The age-adjusted diabetes prevalence rate is 8.0% in Rockland and 6.9% in Orange. Large counts of diabetes are clustered in western Rockland and in Newburgh, Middletown/Port Jervis in Orange. The age-adjusted adult asthma prevalence rate is 10.1% in Rockland and 14.8% in Orange, below the statewide rate (15.2%). There are clusters of elevated asthma risk around Middletown and Newburgh. Cancer incidence per 100,000 across all types is slightly higher than statewide (505.5 and 507.0 vs. 497.3). Breast cancer has a large area of elevated risk encompassing much of Rockland. Colon cancer has a relatively large hot spot in southern Rockland. 7.9% of Orange and 8.1% of Rockland adults report having 14 or more days of poor mental health within the last month. Suicide rates are significantly higher than statewide.

***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:

While the service area generally performed better than NYS on key indicators of maternal and child health, including pre-term births and infant mortality, racial and ethnic disparities are wide. The ratios of non-Hispanic Black and Hispanic pre-term births to White pre-term births is 2.36 and 1.58, respectively, in Rockland County, far exceeding the 2017 PA target. Western Orange County in particular revealed elevated risk for both pre-term and low birth weight births, which was also consistent with higher risk for late or no prenatal care. According to NYS Vital Statistics data for Early Entry into Prenatal Care by County, in 2007 there was a decline in the number of women receiving care during the first 3 months of pregnancy in Orange over a ten-year period. Orange County reported a rate of 54.8% compare to NYS rate of 69.2%. Data from the same source at a later time point (2010-2012) continues to show problematic areas at the zip code level for Percent of Births with Late or No Prenatal Care in 7 zip codes in Orange County.

***Challenges 6:**

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

As noted above, adult and pediatric obesity rates, especially in Orange exceed PA targets and statewide rates, and approximately 1 in 4 adults report virtually no physical activity. Also troubling is the high rate of cigarette smoking in Orange. Among individuals with a behavioral health conditions, smoking rates are much higher (29.9% in Rockland and 30.4% in Orange).

An analysis of the Prevention Agenda indicates 30 of the 44 health status areas that are still in need of improvement in all or portions of the area including low rates of adults who have a regular health care provider and low percentage of children with the recommended number of well-child visits in government-sponsored insurance programs.

***Challenges 7:**

Any other challenges:

While prevalence rates for some chronic conditions are slightly below statewide rates, Medicaid hospitalization rates for many of these conditions are above expected, especially in Orange. For example, the diabetes short-term complications rate was 109% of expected;

admission for ambulatory care sensitive respiratory conditions were 111% of expected. This is indicative of the need for enhanced outreach, access, and care coordination for individuals with or at risk of chronic disease.

Similarly, prevalence rates for some chronic conditions among individuals in the service area with a behavioral health condition are much higher than among the general population. For example, 14% of individuals in Orange County with a behavioral health condition are diagnosed with diabetes, compared to an overall diabetes prevalence rate of 6.9% in the county. This speaks to the need to expand access to integrated behavioral health and primary care services.

Section 3.6 – Healthcare Provider and Community Resources Identified Gaps:

Description:
Please describe the PPS' capacity compared to community needs, in the response please address the following.

***Gaps 1:**
Identify the health and behavioral health service gaps and/or excess capacity that exist in the community, **specifically outlining excess hospital and nursing home beds**.

The biggest gaps in the communities exist due to the fragmentation across provider types and the communication and knowledge barriers preventing access to appropriate care. Each of the 3 identified zip code hot spots in the service area (Newburgh, Middletown, and Spring Valley) contain large clusters of the region's health resources yet also show the largest concentrations of Medicaid beneficiaries with chronic conditions (e.g., diabetes, congestive heart failure, and hypertension) and behavioral health issues (e.g., bipolar disorder, depression, and schizophrenia). This indicates that, while resources may be available, the population is unable to maximize their value. When questioned on the gaps in care within the community, patients, providers, and community groups identified key disparities and barriers, including a need for more coordinated transitions, peer support across the provider spectrum, and more and clearer communication at all levels of care.

Of the patients surveyed, 27% reported receiving care in the ED in the past year. The top reasons given across the Mid-Hudson region were "thought problem too serious for a doctor's visit" and "doctor's office not open." However, 6% reported that the ED was the closest provider. This level of reliance on the ED indicates a need for targeted community-based outreach services to help educate the community on available alternatives.

Provider and peer focus groups with representatives from across the Mid-Hudson region noted a need to develop strategies to break through the existing siloes of mental health, substance abuse, and primary care and establish relationships and coordination among providers. The need for peer support across the continuum of care, including in community-based stabilization services, was also highlighted as was the need for strategies to engage families, partners, and key supporters in developing treatment and wellness plans.

From 2000-2013, the Rockland and Orange County region saw just under a 10% growth in the population, 7% higher than the population of New York State across the same period. In just the last few years, from 2011-2013, Rockland County's Haitian immigrant population grew by 15.4% and its Hispanic population grew by about 26.5%—both populations disproportionately impacted by communication barriers and inadequate access to culturally competent care. This population growth has led to more/higher gaps in access and less excess capacity. Additionally, RCHC hospital partner, Good Samaritan Hospital, participated in a HEAL NY grant bed reduction program over the past 6 years, reducing certified/in service beds from 370 to 286 and reconfiguring units to be more efficient. Current occupancy levels are at their highest and they continue to see growth in demand. Through DSRIP, RCHC and its partners will increase the use of community-based resources, which will better manage the growing demand for inpatient care. Reductions in avoidable hospital use will be offset by projected new hospital use due to population growth.

***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.

18% of patients surveyed who sought health care services outside our counties gave "better care" as the number one reason. Consumers interviewed noted a lack of trust in their health providers and described feeling like "nuts and bolts on an assembly line." Consumers also expressed feeling discriminated against as low-income patients and felt embarrassed to seek care knowing that they may have to disclose

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their insurance or financial status publically.

Of the patients surveyed across the Mid-Hudson region who had a routine physical exam or check-up more than 2 years ago or never at all, 73% said they cannot afford care and 20% said their co-pay for their deductible is too high. (Responses not mutually exclusive.)

Consumers indicated that they did not always obtain clear communications directly from providers due to language barriers. They also noted feeling frustrated by the lack of a single point of contact for information on health issues and support services and few said they had advocates helping them navigate the system.

Those with behavioral health issues and substance abuse disorders are some of the most impacted by the gaps. Although mental health was rated in the top 5 out of 17 health issues, 20% surveyed claimed that they did not know where to go in the counties to access mental health services. Additionally, from 9/1/13 to 9/1/14, 9% of the Medicaid population in Orange County had 1+ behavioral health ED and/or inpatient hospital claim.

The number of family households with 6+ members in the service area is 10% compared to 6% statewide. Large family sizes contribute to added transportation costs and barriers even when traveling short distances. This leads to accessing care that is most convenient rather than most appropriate or delaying/forgoing accessing care altogether.

***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.

RCHC and its partners will increase the use of community-based resources, which will better manage the growing demand for inpatient care. Reductions in avoidable hospital use will be offset by projected new hospital use due to population growth. This will involve providing more primary care and other community-based resources for the existing and growing service area populations; providing culturally competent care; and breaking down transportation, communication, and knowledge barriers.

Increasing access to community-based resources, such as community health workers and care navigators, will ease some of the communities' transportation issues and assist in directing patients to other accessible and appropriate care settings.

Evolving the existing sites of primary care into PCMHs will serve to enhance the quality of care provided and the level of engagement patients feel while accessing care. RCHC will connect patients to care managers, community health workers, and care navigators who will guide them to appropriate health resources and community support services and support the provision of culturally competent care and health literacy education. Providing more integrated care, not only between primary care and behavioral health, but also across the health spectrum will help address myriad access issues, including cost and transportation barriers.

Connecting providers through data sharing will allow for providers to track patients and provide necessary follow up care. Connecting patients with providers through appointment alerts and patient portals will help patients take a more active and involved role in managing their health. Through evidence-based medication adherence programs, patients will be actively engaged in defining their responsibilities and goals and community health workers, patients and their support systems will be more involved in treatment plans better enabling patients to manage their health.

Identification and management of the behavioral health issues of our community will be supported through integrating behavioral health and primary care as well as access to the community-based, peer-supported crisis stabilization services that will decrease the rates of ED visits and hospitalizations and improve patient outcomes.

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:**

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

The three Mid-Hudson PPSs collaborated on creating a single CNA and actively collaborated through weekly calls and almost daily sharing of draft findings.

Stakeholders were engaged throughout the CNA process. The CNA was a standing topic at PAC meetings and webinars. RCHC launched a PPS website (www.RefuahCHC.org) with links to CNA information and findings. RCHC sent links to CNA findings for PAC members to review, provide input, and share with community members and stakeholders.

The CNA team attended more than 60 meetings and webinars, including all RCHC PAC meetings, to share CNA findings and solicit feedback. Prevalence maps, workbooks, and survey results were shared with all community stakeholders through a link on the RCHC's website during a public comment period.

The CNA process included partnering with the county departments of health, departments of mental health, and community services to establish local teams that identified health care and community-based resources and provide outreach to groups affected by DSRIP. Working with county teams has assured representation from special population groups, other health care participants not part of our PPS, and representatives from critical sectors such as schools and work sites.

The CNA included a survey of Hudson Valley residents that gathered information and feedback about demographics and community health needs. The survey was drafted at a 6th-grade reading level and reviewed and approved by health literacy experts. It was available in five languages prevalent in the Mid-Hudson: English, Spanish, Portuguese, French Creole, and Yiddish. It was available online through the RCHC and other PPS websites and conducted at care sites and in community settings by outreach workers. It was publicized throughout the Hudson Valley (e.g., fliers in local grocery stores, pharmacies, and clinics). By December 1, the survey received over 4,700 responses. The survey will remain open through the end of 2014 and final responses will be formally analyzed in January 2015 to inform implementation planning.

RCHC hosted a cultural competency and health literacy strategy session with PAC representatives to identify key challenges, opportunities, and resources for designing and implementing culturally competent PPS systems and projects and enhancing health literacy among county residents.

***Community 2:**

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

The collaborative CNA included 3 mini-groups of consumers that discussed barriers to access and health behaviors and 7 focus groups with over 60 participants representing over 30 organizations that explored topics related to behavioral health and perceptions of current use of services, suggestions about how to better integrate services, and perceptions of current use of EDs. Another focus group conducted with ED providers and frontline workers assessed issues associated with ED utilization. The CNA also included 12 telephone interviews of experts on vulnerable populations, including people with developmental disabilities and incarcerated/formerly incarcerated residents.

RCHC hosted a cultural competency and health literacy strategy session with PAC representatives to identify key challenges, opportunities, and resources for designing and implementing a culturally competent PPS and enhancing health literacy among county residents. RCHC also met with community providers and organizations to jointly identify resources that could be leveraged for the projects.

***Community 3:**

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

Overall findings suggest the need to focus on care transitions; increase peer involvement; and integrate care, especially primary care and behavioral health services. Consumers also indicated a need for expanded primary care access and more information on where and how to access services in communities. Transportation was a common barrier cited, especially for those with large families. In the patient survey, 27% reported receiving care in the ED in the past year, which shows a need for more support to better manage care and increase use of appropriate resources.

Health literacy and cultural competency challenges included lack of access to education; an overemphasis on written patient education;

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inability of providers and staff to communicate in patients' native languages; difficulty recruiting bi/multilingual staff and providers and those that represent the communities served; not enough providers with competencies for patients with special needs; limited understanding among providers about the community they serve; cultural biases embedded into systems; and the lack of systems and knowledge to deliver care from a family perspective.

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.

[Refuah Health Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
1	Ezras Choilim Health Center	Federally qualified health center serving Orange County; a multi-specialty site that is NCQA certified as a Patient Centered Medical Home, Level 3 and serves a large proportion of residents whose primary language is not English and has unique cultural needs.	One of the founders of the PPS, part of on Steering Committee that developed plan, and member of Executive Governing Body.
2	Good Samaritan Regional Medical Center	A non-profit 286-bed acute care facility serving Rockland and Southern Orange County with medical, surgical, obstetrical, renal dialysis, home health and other tertiary services. It is a Level II Trauma Center, Stroke Center and Designated MI Center and provides the regions only open heart surgical program, catheterization lab, electrophysiology lab and pacemaker clinic. GSRMC Home Care agency is Medicare certified and was approved in April 2013 by State of New York to expand into Bronx, Manhattan and Westchester.	One of the founders of the PPS, part of on Steering Committee that developed plan, and member of Executive Governing Body.
3	Hudson River HealthCare (HRHCare)	Federally qualified health center with multiple locations throughout New York's Hudson Valley, including Rockland County, and Long Island. As a Health Home, HRHCare collaborates with health and community agencies that work together to help Medicaid members with serious and chronic health issues get care management and other support services.	HRHCare leads a Hudson Valley Health Home and will serve as a primary care "hub" to contribute expertise, tools, and input based on its experience serving patients through an integrated care model
4	Greater Hudson Valley Family Health Center (GHVFHC)	A federally qualified health center recognized by the National Committee for Quality Assurance as a Level 3 Patient Centered Medical Home and has achieved NCQA's Diabetes Provider Recognition Program. GHVFHC is also a Joint Commission-accredited Ambulatory Care Center. Provides comprehensive primary and preventative healthcare services for nearly 21,000 patients in the Hudson Valley, including Orange County.	Will bring extensive experience with 2014 standards for PCMH certification
5	Joint Membership of Health and Community Agencies (JMHCA)	JMHCA is a coalition of Orange County medical, mental health, and social services providers and the Orange County Department of Health that work together to coordinate and improve care for county residents.	JMHCA helped identify Orange County opportunities for projects and provided input on cultural competency and health literacy; JMHCA member Rehabilitation Support Services Inc. will provide home visits to those Medicaid patients needing more intensive education and tracking of their medical adherence as part of the medication adherence program
6	Cultural Equity Taskforce (CET) in	An affiliate of JMHCA, CET is an Orange County	PPS will contract with them for

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[Refuah Health Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
	Orange County	coalition comprising representatives from human services and county agencies, individuals who receive services, and the community at large and addresses conditions related to inequities.	cultural competency and health literacy support
7	Orange County Department of Health	Local county health department with mission of mission of promoting and protecting the health of Orange County. Offers range of services and programs, including community health outreach; intervention services for developmentally disabled children; emergency preparedness; environmental health; and immunization, flu, STIs, and TB clinics.	Will provide access to their services and program and support the behavioral health crisis project through their mental health crisis line for residents of Orange County
8	Rockland County Department of Health	Local county health department with mission of promoting and protecting the health of Rockland County. Offers a wide range of clinics for families and individuals, including a child health clinic, family planning services, home health care, immunizations/vaccines, infectious disease, flu, STIs, and TB. Coordinates the Rockland County Public Health Priorities Steering Committee, which is a private-public partnership of individuals representing educational institutions, health care providers and health-related organizations, community service organizations, governmental agencies, faith-based organizations, consumers, and the business community that coordinate resources to address local unmet public health needs in Rockland County.	Provided input to the CNA, particularly re: community resources; PPS will contract with them for cultural competency and health literacy support
9	Rockland Paramedics	A non-profit Advanced Life Support Service operating in Rockland County that operates in conjunction with the local volunteer ambulance corps. Operates 7 rapid response vehicles and responds with the volunteer ambulance corps to all medical emergencies.	Will support the behavioral health crisis project through a license as a mobile crisis unit
10	Mental Health Association of Rockland County	Provides an extensive array for programs for adults, young adults, children, and families, including adult and child physical and mental health care management, mental health training, residential programs, substance abuse recovery programs, community education, and many more.	Will provide access to their programs and assistance developing community health workers and care navigator resources and linkages
11	Mental Health Association in Orange County, Inc.	Provides Health Homes care management provider; financial assistance, crisis intervention, prevention, and other services for individuals with developmental disabilities and their families, support to victims of sexual assault and other crimes, peer support for individuals with mental illness, culturally competent advocacy, public education, and other services.	Will provide access to their programs and assistance developing community health workers and care navigator resources and linkages
12	1199 SEIU	Union of healthcare workers in the home care, hospital, and nursing home industries as well as pharmacies, freestanding clinics, and other healthcare settings. The largest local union in the world with nearly 400,000 members throughout New York State, Massachusetts, New Jersey, Florida, Maryland, and the District of Columbia.	PAC members, Will have a seat on the Executive Governing Body, governance committees, and the workforce workgroup; brokered relationship with the 1199 Training and Employment Fund (TEF), which RCHC will use as its training vendor
13	Fidelis Care	The New York State Catholic Health Plan. Provides New York State-sponsored health insurance coverage for more than 1 million children and adults, making Fidelis Care one of the largest government programs-based health insurance plans in New York.	In discussions with RCHC about the implications of DSRIP, including value-based payment

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[Refuah Health Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		Provides coverage for the majority of RCHC Medicaid beneficiaries.	

Section 3.8 - Summary of CNA Findings:

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

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

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

[Refuah Health Center] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
1	Better integration of behavioral health and primary care.	PSYCKES data indicate higher prevalence rates of certain chronic conditions among individuals with behavioral health conditions than the general population (e.g., diabetes). High rates of suicide are also present in the area. Cultural factors within certain populations also enhance the stigma associated with behavioral health treatment. Under integrated models, opportunities for identifying and effectively treating behavioral health and substance abuse conditions are maximized.	NY DOH Prevention Agenda Dashboard (2013-2017) PSYCKES data (9/1/13-9/1/14) Provider and patient focus groups
2	Better integration of all services to support population management and evidence-based care.	Healthcare services in the region are generally fragmented, and a large percentage of adults lack a regular source of primary care. High rates of chronic disease and admissions and ED visits for Ambulatory Care Sensitive Conditions within the region indicate the need to develop integrated delivery systems capable of identifying and managing high-risk populations.	NYS Prevention Agenda Dashboard (2013-2017) BRFSS 2008-2009 SPARCS 2008-2013 Medicaid Chronic Conditions file, 2012
3	Better access to crisis stabilization services.	Approximately 9% of Medicaid enrollees have had at least on behavioral health ED visit or inpatient admission within the past year. Suicide rates in the region are significantly higher than statewide. Ambulance data in Rockland indicates a high number of ambulance runs for psychiatric issues.	PSYCKES data (9/1/13-9/1/14) NYS Prevention Agenda Dashboard (2013-2017) Self-reported data, Rockland Psych-related ambulance runs (time period).

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[Refuah Health Center] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
4	Evidence-Based Medication Adherence Programs Behavioral Health Medication Compliance	Suicide rates in the region are significantly higher than statewide. Ambulance data in Rockland indicates very high rates of ambulance runs for psychiatric issues. Combined, these factors indicate a need to expand access to evidence-based medication adherence and behavioral health crisis stabilization services.	NYS Prevention Agenda Dashboard (2013-2017) Self-reported data, Rockland Psych-related ambulance runs (time period).
5	Better care mgmt to reduce unnecessary admissions and ED visits for ambulatory sensitive conditions.	Prevalence rates for chronic conditions are slightly below statewide but show room for improvement. There are isolated clusters of higher incidence within the area. Orange County Medicaid preventable ED visits have been at or above expected for the last several years. Similarly, Orange County inpatient admissions for multiple PQIs (e.g., diabetes short-term complications, COPD, hypertension) are above expected.	NYSDOH Medicaid Inpatient Prevention Quality Indicators for Adult Discharges by County (2011-2012) NYSDOH Medicaid Potentially Preventable Emergency Visit Rates by County (2011-2012) BRFSS 2008-2009
6	Culturally appropriate community-based navigation services.	The region is home to several large immigrant communities, including several Hispanic and Haitian communities and a very large Hasidic Jewish community. Each of these communities has unique language, literacy, and cultural needs that impact the way they utilize health care services. Culturally appropriate, community-based community health workers and care navigators are critical for reaching these communities. Some sub-regions of the area also have high rates of late entry into pre-natal care and adverse birth outcomes, indicating the need to ensure access to navigation services.	Census data, Tables B03002 and S1603 NYS Vital Statistics data, 2007, 2010-2012
7	Evidence-based smoking cessation services, especially for low SES or those with poor mental health.	Adult smoking rates in Orange exceed PA targets, and oral cancer rates in the county exceed the statewide rate. Among individuals with a behavioral health condition in the region, smoking rates are extremely high (approximately 30%), and utilization of smoking cessation medications (11%) and counseling (46%) by smokers is quite low.	NYOMH, PCS Survey, 2013 NYS Prevention Agenda Dashboard (2013-2017) Source:2009-2011 Cancer Registry Data as of April, 2014
8	Increased/more comprehensive mobile care to provide access to those facing transportation barriers.	The number of family households with 6+ members in our community is 10% compared to 6% statewide. Large family sizes contribute to added transportation costs and barriers even when traveling short distances. This leads to accessing care that is most convenient rather than most appropriate or delaying/avoiding accessing care altogether.	Census data, table B11016 Patient surveys and focus groups

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

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File Name	Upload Date	Description
20_SEC038_GCommunityBasedOrganizationsWorkbook.pdf	12/19/2014 12:40:03 PM	Appendix G - COMMUNITY BASED ORGANIZATIONS WORKBOOK
20_SEC038_F_Health Care Resources_121014.xlsx	12/19/2014 12:39:00 PM	Appendix F - HEALTH CARE RESOURCES
20_SEC038_ECommunityProfiles_IncludingHealthOutcome.pdf	12/19/2014 12:36:44 PM	Appendix E - COMMUNITY PROFILES INCLUDING HEALTH OUTCOMES
20_SEC038_D3CRHI-Community-Needs-Assessment-Lower-Hudson-Valley-Seven-County-Disease-Prevalence-Clusters.pdf	12/19/2014 12:34:50 PM	Appendix D3 - CNA LOWER HUDSON VALLEY SEVEN COUNTY DISEASE PREVENTION CLUSTERS
20_SEC038_D2Bene_Summary_Tables_COUNTY_and_ZIP_PLUS_CANCERS_100214.pdf	12/19/2014 12:33:39 PM	Appendix D2 - BENEFICIARY SUMMARY TABLES COUNTY AND ZIP PLUS CANCERS
20_SEC038_D1Mapping Methodology for Medicaid Beneficiaries for Selected MDC_EDC VolByZip.pdf	12/19/2014 12:32:05 PM	Appendix D1 - MAPPING METHODOLOGY FOR MEDICAID BENEFICIARIES FOR SELECTED MDC EDC VOLUME BY ZIP
20_SEC038_CPrevalence Rate Mapping Methodology_SatScan Statistic.pdf	12/19/2014 12:31:18 PM	Appendix C - PREVALENCE RATE MAPPING METHODOLOGY STAT SCAN STATISTICS
20_SEC038_B2HousingStudy.pdf	12/19/2014 12:30:47 PM	Appendix B2 - HOUSING STUDY
20_SEC038_B1CommunityProfiles-SESBuiltEnvironment.pdf	12/19/2014 12:29:43 PM	Appendix B1 - COMMUNITY PROFILES - SES BUILT ENVIRONMENT
20_SEC038_A4HIT_HIE SurveyofCapabilities_InstrumentandResults.pdf	12/19/2014 12:26:19 PM	Appendix A4 - HIT HIE SURVEY OF CAPABILITIES INSTRUMENT AND RESULTS
20_SEC038_A3DSRIP Organization Input Sheet_FINAL_CulturalCompetency.pdf	12/19/2014 12:23:24 PM	Appendix A3 - DSRIP ORGANIZATION INPUT SHEET CULTURAL COMPETENCY
20_SEC038_A2CommunitySurvey_InstrumentandResults.PDF	12/19/2014 12:21:36 PM	Appendix A2 - COMMUNITY SURVEY INSTRUMENTS AND RESULTS
20_SEC038_A1Focus Groups_Recruitment ProcessGuidesandResults.pdf	12/18/2014 07:06:42 PM	Appendix A1 - FOCUS GROUPS
20_SEC038_ONE REGION_FULL CNA REPORT_FINAL_120914.pdf	12/18/2014 07:03:19 PM	CNA Final Report (ONE REGION, ONE CNA)

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

DSRIP PPS Organizational Application

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SECTION 4 – PPS DSRIP PROJECTS:

Section 4.0 – Projects:

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

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

Please upload the Files for the selected projects.

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

Currently Uploaded File: **Refuah_Section4_Text_RCHC_DSRIP Project Plan Application _ Section 4 Part I(text).docx**

Description of File

RCHC Project Plan Application, Section 4 Part I

File Uploaded By: refuah

File Uploaded On: 12/21/2014 09:31 PM

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

Currently Uploaded File: **Refuah_Section4_ScopeAndScale_RCHC_DSRIP Project Plan Application _ Section 4 Part II (Scale & Speed).xlsx**

Description of File

RCHC Project Plan Application, Section 4 Part II, Scale & Speed

File Uploaded By: refuah

File Uploaded On: 12/22/2014 01:31 PM

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SECTION 5 – PPS WORKFORCE STRATEGY:

Section 5.0 – PPS Workforce Strategy:

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

The following subsections are included in this section:

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

Scoring Process:

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

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

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

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

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

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

To assess the impact on workforce, the Refuah Community Health Collaborative (RCHC) conducted an analysis of population trends, current utilization, and inpatient and ambulatory care capacity and considered the projected impact of the transformational projects outlined in this application. RCHC concluded that there will be a need for significant expansions to workforces, offering new employment opportunities for existing and new workers. This will include new care managers, care coordinators, community health workers, care navigators, and behavioral health providers. Additional workforce at the PPS level will support administrative functions on behalf of the PPS, including IT system supports, data analytics and reporting, project management, quality oversight, population health management, and provider practice transformation. Existing and new workers will all require extensive training to operate in a new integrated care

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system. Training plans for new hires and providers and staff will be based on a comprehensive workforce assessment of all partners during the implementation planning phase. The assessment will enable RCHC to align those needs with the 7 projects and ensure strong stakeholder and worker engagement. It also will be done in collaboration with the other 2 Mid-Hudson PPS to ensure a region-wide workforce development strategy that avoids duplication of effort and makes prudent use of resources.

While RCHC expects significant expansions to workforces, no staff reductions or redeployments are anticipated. This is in large part because RCHC hospital partner, Good Samaritan Hospital, participated in a HEAL NY grant bed reduction program over the past 6 years, reducing certified/in-service beds from 370 to 286 and reconfiguring units to be more efficient. Current occupancy levels are at their highest and they continue to see growth in demand. Through DSRIP, RCHC and its partners will increase the use of community-based resources, which will better manage the growing demand for inpatient care. Reductions in avoidable hospital use will be offset by projected new hospital use due to population growth. Based on current staffing capacity and projected needs for new hires, no staff are expected to be shifted to and retrained for different positions. If a staff member voluntarily requests a different role, it would be handled as career development under human resource policies and processes.

Achieving transformation goals requires the entire PPS workforce to learn and adapt to the core PCMH care model, team-based roles and functions, and re-engineered processes of care. All clinicians will be trained on a core set of skills related to population health, interdisciplinary care teams, shared care plans, performance improvement, cultural competency, and health literacy. Other major areas of impact for current and new staff: RNs/NPs will be trained on enhanced care management team functions, chronic care management, and behavioral health integration. Behavioral health providers will be trained on integrated physical and behavioral health models. Care managers will be trained to manage physical and behavioral health care. Administrative staff will be trained to support the operation of an Integrated Care Delivery System, patient-centered customer service skills for staff who interact with patients, monitoring and reporting, and value-based payment. Union and Nonunion: All workers will be included in training. No negative impact on union positions is anticipated.

RCHC's workforce strategy will seek to leverage both current and emerging titles and roles across its partners, while building career pathways and skill enhancement opportunities for existing and new staff. For example, community health workers, medical assistants, and care navigators may advance into other positions such as care coordinators and managers.

***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.

RCHC recognizes that multifaceted efforts are required to optimize the current workforce and expand in ways that support a transformed delivery system. RCHC does not anticipate shifting to and retraining staff for different positions (i.e., neither full nor partial placement) or reducing and redeploying staff.

The workforce strategy includes 5 key components related to retraining:

1. Conducting a comprehensive workforce assessment during the implementation planning phase to assess options for new hires, training and skill development needs of existing providers and staff, perceived workforce impacts and concerns, credentials.

2. Training existing providers and staff on new roles and skills needed to operate effectively in an Integrated Delivery System in their current positions.

3. Creating career pathways for existing staff to advance into new positions. This will be an essential staff retention and workforce development strategy.

4. Hiring new providers and staff new roles and positions, including care managers, care coordinators, community health workers, care navigators, and behavioral health providers.

5. Worker engagement and change management strategies to minimize loss of staff due to concerns about potential negative impacts.

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This will include engaging frontline workers and providers to be part of a workforce workgroup and conducting focus groups and interviews with workers as part of the comprehensive workforce assessment.

These strategies will be developed in collaboration with the other 2 Mid-Hudson PPS to ensure a region-wide workforce strategy that avoids duplication of efforts and ensure prudent use of resources.

Rockland and Orange county have experienced shortages of primary care providers, pharmacists, nursing and care managers, and behavioral health specialists, including psychiatrists. RCHC partners have conducted initial assessments of anticipated recruitment needs based on projected additions to staff that will be required by projects. An adequate supply of primary care providers, nursing, and care managers is vital as they play core roles in team based care and necessary to ensure effective implementation of PCMH practices necessary for PCMH certification. Behavioral health specialists are needed to staff navigation, crisis stabilization, and primary care behavioral health integration projects. RCHC plans to hire new personnel to fill these shortages. RCHC will implement recruitment strategies for additional providers and staff through the use of marketplace recruiting firms and tools, engaging existing provider champions for outreach, expanding relationships with colleges/universities, recruitment events, participation in the State's workforce programs, and support from AHEC and the 1199 Training and Employment Fund (TEF). The projects also call for hiring new community health workers and care navigators, which are essential for the Medication Adherence Program and Care Navigation project. They will be recruited from the lay service area population, which presents employment opportunities and potential career pathways for community members. Recruitment strategies also will be developed in collaboration with the other 2 Mid-Hudson PPS as part of a region-wide workforce strategy.

***Strategy 3:**

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

Workforce Implication	Percent of Employees Impacted
Redeployment	0%
Retrain	85%
New Hire	2%

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.

RCHC's training plan will be based on the needs of each project and findings from the comprehensive needs assessment that will be conducted in the implementation planning phase. RCHC has identified the 1199 Training and Employment Fund (TEF) as a training vendor who can provide assistance to the PPS. TEF has the capabilities to assist RCHC in conducting a comprehensive workforce assessment and identifying new roles, job descriptions, specific skills, and credentials needed. TEF has the resources to conduct multiple trainings that focus on engaging the healthcare workforce in transformation and training them on advanced models of care (e.g., interdisciplinary care teams, care management and coordination, home care, care navigators, community health workers, etc.) and the skills to fulfill project requirements and improve outcomes. TEF uses the City University of New York wherever possible to deliver training programs that offer college credit or where high quality workforce and certificate programs meet industry needs.

RCHC also will contract with the Cultural Equity Taskforce in Orange County and the Rockland County Health Department for cultural

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competency and health literacy trainings and other support. Both organizations have been leaders in their communities on such topics and will provide trainings and, as appropriate, contract with training and/or subject matter experts.

RCHC will collaborate with the other 2 PPS in the region in order to assess and align workforce strategy to clinical/patient needs, aggregate demand for training, and avoid duplication of effort. Training will be conducted by expert clinical staff, experienced educators in adult learning theory and organizational development experts.

Because training is essential to implementing the DSRIP projects and transforming care delivery, the workforce retraining will not be voluntary. Where new credentials or skills are needed for specific incumbent job titles, the training or credential may be mandatory (e.g., care management certification).

***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.

RCHC is anticipating job increases rather than losses. Therefore, retraining will focus on enhancing skills and preparing providers and staff for new roles in their current positions. RCHC also will develop pathways for current staff to advance in their careers. RCHC will use a wage and career ladder job analysis to inform wages and benefits for existing and new staff. This will be a collaborative effort of stakeholders and labor unions.

As supported by PAC members, RCHC also will assess wages and benefits for new positions against living wage standards to ensure that compensation meets minimum standards of living. This will be especially important for positions for lay workers (e.g., community health workers and care navigators).

***Retraining 3:**

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

RCHC does not anticipate any redeployment due to job reductions. RCHC will establish a process to educate all employees regarding the changes that are anticipated as a result of system transformation. Providers and staff will know well in advance how their roles within their current positions might change, what skills they will need to acquire, and which new positions will be developed. RCHC will consult with the 1199 Training and Employment Fund to develop mechanisms to support providers or staff who seek voluntary changes in positions.

***Retraining 4:**

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

Labor representatives will play an integral role in this retraining plan. They will participate in the workforce workgroup that will develop the workforce implementation plan and PPS-wide comprehensive workforce assessment. Representatives will be on the Executive Governing Body that will have oversight of the workforce plan, governance committees, the workforce workgroup, and collaboration with the other 2 other Mid-Hudson PPS to assess and align workforce strategy to clinical/patient needs, aggregate demand for training, and avoid duplication of effort. RCHC also has identified the 1199 Training and Employment Fund as a training vendor who can provide assistance to the PPS.

***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	0%
Partial Placement	0%

Section 5.3 - WORKPLACE RESTRUCTURING - REDEPLOYMENT OF EXISTING STAFF :

Description:

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Please outline expected workforce redeployments.

***Redeployment 1:**

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

RCHC does not anticipate any redeployment due to job reductions. This is in large part because hospital partner, Good Samaritan Hospital, participated in a HEAL NY grant bed reduction program over the past 6 years, reducing certified/in-service beds from 370 to 286 and reconfiguring units to be more efficient. Current occupancy levels are at their highest and they continue to see growth in demand. Through DSRIP, RCHC and its partners will increase the use of community-based resources, which will better manage the growing demand for inpatient care. Reductions in avoidable hospital use will be offset by projected new hospital use due to population growth.

***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.

RCHC does not anticipate any redeployment due to job reductions.

***Redeployment 3:**

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

RCHC does not anticipate any redeployment due to job reductions.

***Redeployment 4:**

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

RCHC does not anticipate any redeployment due to job reductions.

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.

New jobs will be created in several categories. At the PPS level, RCHC will support PPS administration through a Project Management Office that will be responsible for directing the implementation of DSRIP projects and ensuring performance. Staff will include a Chief Executive Officer, Medical Director, Director of Program Information and Innovation, and a Compliance Officer. Nine new hires are anticipated for the Project Management Office overall.

At the service delivery level, additional jobs will also be created. This will include new care managers and care coordinators to support patient care teams, fulfill PCMH requirements, and manage care transitions; community health workers and care navigators who will provide patient outreach and support for medication adherence and care navigation in clinical and community-based settings; and behavioral health providers who will be part of new integrated care models and crisis stabilization services. These positions will be hired by either RCHC or partners based on project needs and the scale and speed of project implementation.

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	9
Mental Health Providers Case Managers	14

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Position	Approximate Number of New Hires
Social Workers	3
IT Staff	1
Nurse Practitioners	1
Other	14

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	125,000	62,500	2,500	22,500	0	212,500
Redeployment	0	0	0	0	0	0
Recruiting	42,000	20,000	27,000	5,000	0	94,000
Other	219,904	204,000	203,500	201,000	200,000	1,028,404

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.

RCHC will leverage all available state and federal programs that support provider and staff recruitment, retention, and training. When Doctors Across New York accepts applications again, RCHC will support physicians in applying for the loan repayment programs. RCHC also will use the Primary Care Service Corp loan repayment program for other eligible clinicians. These programs will be significant recruitment tools. RCHC also will support eligible providers to apply for HRSA's National Health Service Corps program, loan repayment program for eligible primary care providers (MDs, NPs, LCSWs, PAs, HSPs, etc.).

RCHC will use the 1199 Training and Employment Fund to support recruitment and the Area Health Education Center (AHEC) to help recruit and train students from minority and disadvantaged backgrounds.

RCHC also recognizes that the pool of state and federal workforce programs is constantly evolving. Thus RCHC's workforce workgroup will regularly assess and identify workforce programs that can support RCHC's recruitment and retention efforts and make recommendations to the Operations Committee.

Section 5.7 - Stakeholder & Worker Engagement:

Description:

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

***Engagement 1:**

Outline the steps taken to engage stakeholders in developing the workforce strategy.

RCHC surveyed of all provider partners about their unionized staff and FTEs for certified/uncertified case managers by type, providers, and trained/untrained interpreters. The survey provided baseline information for the workforce strategy. RCHC also surveyed PAC members about their project participation, which was used to develop workforce estimates.

The CNA included a workforce survey that asked partners about the anticipated impact of DSRIP projects, including four RCHC projects, on their personnel. The assessment showed a need for more case managers, particularly for the IDS and PCMH project, and community health workers. No one responded that they expected any provider type for any project would decrease.

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RCHC obtained input on the workforce approach at PAC meetings, including on retraining, redeployment, and hiring and workforce workgroup membership. PAC members asked that living wages and all types of providers be included in the workforce assessment in the next phase.

***Engagement 2:**

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

All 6 unions representing workers at RCHC partners were invited to participate in the PAC, which included presentations and input on RCHC's workforce approach. RCHC consulted directly with SEIU 1199—the predominant union representing workers at RCHC's partners—on the workforce strategy. The 1199 PAC representative encourage the formation of a workforce workgroup with union representatives, frontline workers, and workforce experts. In response, RCHC will launch a workforce workgroup at the beginning of implementation planning.

RCHC met with 1199 SEIU and the 1199 Training and Employment Fund (TEF) to learn more about the training they provide. Based on that meeting, RCHC has identified TEF as a training vendor who can provide assistance to the PPS.

***Engagement 3:**

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

Frontline workers were members of RCHC's clinical workgroup, which selected and designed projects and made workforce recommendations. Frontline workers have been included in all PAC meetings and workforce presentations and discussions. PAC members encouraged to ensure that the workforce assessment include analyses of living wages among employees and that the final plan and budget include living wages across all staff.

Frontline workers will also have representation on the workforce workgroup during the implementation planning phase. Frontline workers will be engaged in the comprehensive workforce assessment, which will include but not be limited to focus groups and interviews with frontline workers. Iterations of draft workforce plans will be shared with the workgroup and at PAC meetings for input as well as on the RCHC website and via e-mail alerts. Frontline workers also will be included in the Governance Committees and workgroups during implementation.

***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.

RCHC will launch a workforce workgroup to engage partners and frontline workers in a comprehensive workforce assessment and workforce implementation plans. Based on the assessment, the workgroup will help refine the workforce estimates and develop retraining, redevelopment, and new hire plans. This workgroup will comprise 10-12 members representing SEIU 1199, NYSNA, community organizations, workforce experts, and clinicians and frontline workers from FQHCs and behavioral health, development disability, long-term care, and home care providers.

This workgroup will assess and identify project needs and potential solutions to structural barriers and present options to the PAC for input. Draft workforce plans will be shared at PAC meetings for input as well as on the RCHC website and via e-mail alerts.

RCHC's Project Management Office will provide oversight for the workforce plan, monitor workforce issues, and conduct periodic PPS-wide workforce assessments to identify needs and gaps.

Section 5.8 - Domain 1 Workforce Process Measures:

Description:

Progress towards achieving the project goals and core requirements specified above will be assessed by specific milestones for the DSRIP program, which are measured by particular metrics. Investments in technology, tools, and human resources will strengthen the ability of the Performing Provider Systems to serve target populations and pursue DSRIP project goals. Domain 1 process milestones and measures will

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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.

Requirements for data sharing will be included in the creation of the Refuah Community Health Collaborative (RCHC) Data/IT Governance Document, which will include data sharing policies, including requirements that partners use specific solutions that meet minimum standards. Requirements will include but not be limited to exchange of CCD/A documents, DIRECT messages, alerts with THINC for HIE, and data exchange with a PPS data warehousing and analytics solution for quality and population reporting. All PPS partners will be required to adopt the document and adhere to its policies and procedures. The RCHC Executive Governing Body will approve any changes to this document. The Project Management Office will confirm partner adherence.

The type of connectivity utilized (automated vs. manual processes) will be determined based upon partner size, patients served, existing IT capabilities and implementation phase.

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

A Data/IT Governance Committee will be established, including leadership IT roles from the 3 founding partners and data stewards identified from the PPS. It will create a Data/IT Governance and Data Sharing document for enterprise data governance in DY1 Q1 using existing policies and BAA documents from the lead partners as best practices. The final version will be approved by the Executive Governing Body and all partners will be required to adopt the document by DY1 Q1. The document will include policies/procedures meeting HIPAA and HITECH requirements and require:
- Use of RCHC approved BAA and participation agreements with all partners' 3rd party vendors
- Policies for minimum security and audit capabilities for all PPS' solutions including individual partner or PPS-wide software, HIE platforms, and 3rd party vendors
- Audit policies to be carried out by the Project Management Office
- Specific patient consent language for shared data access and via PPS or SHIN-NY solutions.

***Confidentiality 3:**

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

RCHC Data/IT Governance policies will require partner participation in the existing THINC HIE, including exchange of CCD/A, Direct messaging, and alerts. These services are considered "dial tone" services from THINC, and will provide real-time data sharing among partners and other non-PPS organizations via SHIN-NY. RCHC will adopt a PPS-wide data warehousing solution for quality and population reporting. RCHC will require a standardized patient consent for each organization to view/share data through these solutions.

A PPS data warehousing and analytics solution will combine specific patient data from all provider partners to allow for enterprise-wide quality reporting and analytics on projects. Key performance indicators for selected PPS' projects will be developed within the solutions for ongoing quality monitoring. These will include preventable ED and inpatient use, 30-day readmissions, patient engagement indicators for Domain 2 and 3 projects, and PCMH metrics.

RCHC will develop policies with the Clinical Governance Committee to create specific workflow requirements that enable real-time care to patient. These workflows will address the use of all EMR/care coordination platforms, CCD/A, Direct messaging, alerts and data warehousing & analytics in clinical and community care.

The RCHC Compliance Office will perform regular audits and reporting to assure that security and patient privacy are maintained according to all Data/IT Governance policies and will address any issues with remediation or failure to comply.

For RCHC partners not meeting Data/IT Governance policies, clinical workflows, or other PPS requirements, RCHC will provide assistance to select and implement new solutions and/or workflows. Implementation of HIE, data warehousing, and analytics; new solutions; and workflows will be done in a phased manner. Partners will be assigned to specific phases based upon PPS project requirements, current IT capacity, partner size, and patients served.

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.

RCHC will establish an RCE workgroup to drive successful transformation. This workgroup will be led by the Chief Medical Officer and will include a member responsible for overseeing any required data analysis and a provider-level representative for each of the 7 implemented projects. The workgroup will meet monthly to review tracked results and discuss improvement strategies. The group will prepare analyses based on the outcomes of the RCE to the Executive Governing Body at least quarterly. In addition to quality metrics, these reports will include detailed descriptions of the population-based interventions tested within each project, the impact those interventions have had on the progress toward project goals, and the recommendations for modifying, expanding to a larger population, or disregarding interventions. The 7 project representatives will be accountable for fostering a culture of continued improvement and for communicating and implementing any Executive Governing Body directives, including quality improvement actions and modifications to population-based project approaches, at the provider level.

***RCE 2:**

Outline how the PPS intends to use collected patient data to:

- Evaluate performance of PPS partners and providers
- Conduct quality assessment and improvement activities, and

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

The team will uniformly monitor project metrics and interim goals across providers. Dashboards will be developed and available for real-time evaluation at the workgroup and individual provider level in order to provide benchmarking, peer ranking, and performance measurement. These dashboards will include the clinical metrics required for each of the 7 projects and other interim measures of health improvement across targeted populations (e.g., missed appointments and prescription refills). The analytics tool will also have the capacity to alert providers if specific thresholds are exceeded. Monitoring these components will help to inform RCHC of progress toward overall goals and reveal variations in quality of care across the PPS system. RCHC will use this performance tracking to test variations in population-based activities and tools (e.g., variations in the medication adherence tool) across segments of the target populations.

***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).

While providers will have real-time access to the dashboards, the workgroup will track patient data weekly to quickly identify and act on any significant variations in metrics. The 7 project representatives will oversee communication of outcomes and progress to providers and other members as appropriate and will be responsible for addressing noted discrepancies in care and improvement related to their project implementation at the provider level. The workgroup will prepare analyses based on the outcomes of the RCE and make recommendations to the Executive Governing Body at least quarterly. In addition to the required tracked project metrics, these reports will include detailed descriptions of the population-based interventions tested within each project, the impact those interventions have had on the progress toward project goals, and the recommendations for modifying, expanding to a larger population, or disregarding interventions.

***RCE 4:**

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

Through the use of RCE, our PPS will continuously assess and improve the quality of care provided across the integrated system and the impacts project components and population-based strategies have on the health and wellness of our patients. By analyzing quality, tools, and interventions uniformly and in real time through a comprehensive data collection, RCHC will have the opportunity to address and improve inconsistencies in care at the provider level, modify or abandon failing approaches, and put in place new initiatives to drive the success and sustainability for the PPS. The RCE will also allow RCHC to hone in on the most appropriate approaches to care across separate and diverse populations and thereby improve the health of the harder-to-reach patients within 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.

Rockland and Orange Counties are home to diverse populations. African Americans present 10% of the population and Hispanics 17%. There are several large, growing immigrant communities, including Hispanic and Haitian communities and one of the largest Hasidic Jewish communities in the US. Rockland's Haitian population has grown by 15.4% from 2009 to 2012, and its Hispanic population grew by 26.5% in the same period.

The Refuah Community Health Collaborative (RCHC) conducted a strategy session with PAC representatives from both Rockland and Orange Counties to identify cultural competency challenges and resources. As part of the CNA, surveys and focus groups were conducted to assess providers' perceptions of capacities and issues related to culturally competent care.

The process revealed the following cultural competency challenges that must be addressed: the inability of providers and staff to communicate in patients' native languages, particularly Spanish, Portuguese, French Creole, and Yiddish; difficulty recruiting bi/multilingual staff and providers and those that represent the communities served; not enough providers with competencies related to patients with special needs (e.g., mental health providers who provide trauma-informed care for distinct populations); limited understanding among providers about the community they serve, including changes in community demographics and barriers to care; cultural biases embedded into systems (e.g., policies and procedures, patient intake forms, health risk assessments); and the lack of systems and knowledge to deliver care from a family perspective.

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***Competency 2:**

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

The goal of RCHC's strategic plan is to develop a PPS that promotes cultural inclusion/competence, linguistic access, and health equity and ensures that providers and staff have the knowledge and skills to deliver services that are respectful of and responsive to the health beliefs, practices, and cultural and linguistic needs of diverse patients. RCHC's plan will include activities to track and reduce health disparities across ethnic, racial, cultural, social, and economic groups while prioritizing equal access, which influences quality of care and healthcare outcomes.

RCHC will contract with two community-based organizations for cultural competency support and training. The cultural competency plan will include assessing PPS partner organizations using a National Center for Cultural Competence tool by Q2 DY1. Based on the assessment, they will develop a work plan for training leaders, providers, and frontline workers on community demographics, cultural competency, health disparities, heath equity, and select topics (e.g., family-centered care, trauma-informed care). Training will begin by Q3 DY1. The plan will include conducting periodic assessments and developing annual action plans.

Beginning in Q3 DY1, contracted organizations will work with the Clinical Governance Committee to develop mechanisms to track health disparities. They will work together to address improvements to aspects of the delivery system, including changing policies and procedures, forms, clinical tools, and patient materials to support cultural competence, and to develop a PPS-wide plan to recruit and retain providers and staff that reflect the patients they serve.

Progress will be monitored by the Clinical Governance Committee monthly and the Executive Governing Body quarterly.

***Competency 3:**

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

During the strategy session, PAC members provided input on existing and trusted resources for improving cultural competency. Based on that input, RCHC will contract with the Cultural Equity Taskforce (CET) in Orange County for cultural competence support and training. CET comprises representatives from human services and county agencies, individuals who receive services, and the community at large and addresses conditions involving but not limited to race, gender, economic disparity, ethnicity, religion, gender identity, language, disabilities, sexual orientation, and age. RCHC will contract with the Rockland County Health Department in Rockland County.

The contracted organizations will be responsible for developing and executing annual cultural competency improvement plans for PPS providers in the service area. They also will be responsible for conducting periodic assessments of cultural competency needs in the service area.

The contracted organizations will report progress to the Clinical Governance Committee monthly and to Executive Governing Body quarterly. They may, as appropriate and as approved by the Executive Governing Body, subcontract with other community-based organizations for portions of work.

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.

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***Literacy:**

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

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

RCHC's health literacy plan is based on findings from a strategy session with PAC representatives to identify health literacy challenges and resources and CNA surveys and focus groups. Both revealed a lack of access to education/health literacy classes as well an overemphasis on written patient education vs. verbal or picture-based instruction. The plan will emphasize patient and community outreach and education, provider and staff education, and systems changes.

The work will include conducting an assessment of all provider practices using the AHRQ assessment tool and developing action plans based on findings and the U.S. Department of Health and Human Services Health Literacy guidelines. RCHC will emphasize assessing and developing health literacy plans in high-risk situations, including care transitions and communications about medications.

RCHC will implement evidence-based interventions, including implementing Plain Language guidelines for all patient materials across all partners. RCHC will implement systems changes and tools that support health literacy assessment and communication and train all providers, pharmacists, and frontline staff on key tools and skills (e.g., Test of Function Health Literacy in Adults, visual/multi-media communication, "teach back" techniques). RCHC will implement health literacy group education programs in primary care settings. RCHC will train community health workers and community navigators to support health literacy among patients. Specific health literacy goals and activities will be included in RCHC's quality improvement and patient safety work plans and evaluations and reported to the Clinical Governance Committee and the Executive Governing Body. Existing health literacy educational curriculum also will be added to existing adult literacy programs in each county (e.g., Rockland Literacy Corps, Literacy Orange).

RCHC will contract with the Cultural Equity Taskforce (CET) in Orange County and the Rockland County Health Department in Rockland County to support health literacy support and outreach. They will be responsible for developing and executing annual health improvement plans across the service area. They also will be responsible for conducting periodic assessments of health literacy needs in the service area. The contracted organization will report progress to the Clinical Governance Committee monthly and to Executive Governing Body quarterly. They may, as appropriate and as approved by the Executive Governing Body, subcontract with other community-based organizations for portions of work.

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

Description:

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

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

Please click here to acknowledge the milestones information above.

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SECTION 8 – DSRIP BUDGET & FLOW OF FUNDS:

Section 8.0 – Project Budget:

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

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

Scoring Process:

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

Section 8.1 – High Level Budget and Flow of Funds:

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

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

The guiding principles that are the foundation for the Refuah Community Health Collaborative's (RCHC) budget and funds flow include adequate infrastructure funding, insuring the sustainability of the PPS network, and rewarding all partners to incentivize behaviors and achieve performance. DSRIP incentive payments will be allocated to several budget pools consistent with these guiding principles. First, funds will be allocated to cover the infrastructure costs of the PPS including administrative and technology costs related to the DSRIP program. 2 additional pools of funds will be set aside for contingencies and innovation. The remaining pools, which will account for a majority of the DSRIP funding, will fund revenue loss due to DSRIP project implementation, project implementation costs, new supportive costs not currently paid by Medicaid, and provider bonus payments.

The distribution protocols for these funds will differ by pool category and will be driven by partner specific budgets, requests and performance for the projects they participate in. All partners will have access to funding for the cost of implementation, enabling/supportive costs and revenue loss due to DSRIP project implementation; distributions will be based on individual partner needs by project approved by RCHC. Partner bonus payments will be driven by meeting and/or exceeding agreed to performance metrics/milestones. In addition, penalties will be assessed for continually poor performing providers and providers who do not implement restructuring or sustainability plans. All partners will also have access to contingency and innovation funds through an application process. RCHC has also approved a distribution protocol to allow for 5% of DSRIP funds to be awarded to non –qualifying DSRIP partners to incentivize community based organizations that impact DSRIP outcomes. As the DSRIP plans are implemented, the pool funding percentages will change, presumably moving away from implementation cost and revenue loss in the early years to bonus payments in the out years. As the objectives of the design of the funds flow are to incentivize behaviors of all providers to attain the DSRIP goals, all partners from across the continuum of care are expected to participate in and receive DSRIP funds, assuming their performance warrants it.

The budget and funds flow structure and approval processes all filter up to the Executive Governing Body. Since this Body will be comprised of representatives from each provider type, this structure insures that the impacts, goals and rewards take into account all

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provider types across the continuum of care. The allocation model and funds flow has been approved by the Steering Committee and presented to the PAC with no additional comments. In addition, partner- and project-specific funding requests as well as pool allocation percentages will be reviewed by the Finance Governance Committee and then submitted to the Executive Governing Body for approval on an annual basis.

As a majority of the DSRIP incentive payments are designed to reward project-specific performance and distributed down to individual providers, the funding is being provided to drive behaviors that attain DSRIP goals. Compensation to partners for lost revenue and costs of implementation will avoid undue hardship on financial operations during DSRIP; the provision of bonus payments on top will then incentivize behaviors. The funds flow also provides funding to financially fragile organizations to assist with their pathway to financial stability as well as potential funding for one-time, unforeseen circumstances and new innovative ideas. Other pools that may become available for distribution include additional DSRIP payments from a statewide high performance pool as well as possible dollars from shared savings arrangements with MCOs executed during the DSRIP project period.

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	15%
3	Internal PPS Provider Bonus Payments	40%
4	Costs for services not covered (Costs for services not covered by Medicaid; Additional/innovative services (community-based))	10%
5	Contingency pool; Reserve for unanticipated events/conditions; Funding to fill funding gaps for partners to achieve DSRIP goals and incentivize marginally performing providers to achieve DSRIP goals	5%
6	Other (Funding to partners for innovative approaches/ideas)	5%
	Total Percentage:	100%

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

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

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- 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.

To assess the financial health of the PPS, the Refuah Community Health Collaborative (RCHC) Steering Committee approved a multi-pronged approach to evaluating the PPS network. Initially, a review of the IRS Form 990 tax filings and the OMIG website for potential Medicaid issues of partners was conducted. The results of this initial assessment did not identify any major concerns.

Subsequently, surveys were distributed to all partners, which gathered information on balance sheet indicators, operating metrics, patient volume and payer mix, and other financial metrics over a 3-year period to understand trends by provider type. RCHC compiled preliminary results from these surveys and developed a methodology that grouped partners by provider type. RCHC then ranked the organizations by financial strength and those most sensitive to changes in reimbursement. A second assessment was then preformed to layer on top how the DSRIP projects and the broader health reform initiatives may impact the future financial stability of providers. This included a sensitivity analysis of projecting reduced hospital use as a result of DSRIP projects on hospital revenue. Preliminarily, these assessments indicate that Skilled Nursing Facilities as well as certain behavioral health organizations may be the weakest provider groups within the PPS network.

The list of identified financially fragile partners will be reviewed with the Steering Committee in January 2015. Once the final list of financially fragile providers is approved, RCHC will be contacting these targeted financially fragile partners to request additional financial information to evaluate operating and financial trends and discuss pathways to financial sustainability. Stability plans and the potential

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needs for funding will be compiled and presented to the Executive Governing Body in March 2015.

***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.

Given RCHC's selection of DSRIP projects, most of the goals are aligned with improving primary care services and care management and coordination across providers. As the health of the population improves, we foresee a decrease in avoidable hospitalizations and emergency department (ED) utilization, which could have a short-term impact on inpatient revenue in hospital and nursing home settings. The shift towards primary care will put pressure on hospitals to develop other lines of business to sustain operations until they are able to benefit from shared savings.

Aside from DSRIP, providers in RCHC's network will have additional financial pressures that will impact sustainability. Payers like Medicare are reducing payments for inpatient care as well as reductions in Disproportionate Share Hospital payments. Other providers are moving into Medicaid managed care with dramatic changes in their reimbursement models forthcoming. Governmental fiscal crisis plus health reform efforts may reduce or eliminate State-supported deficit grants or uncompensated care pools.

Specific to DSRIP, the initial expectation of the financial impacts DSRIP projects will have on partners include:
- Reductions in avoidable hospital use will drive down inpatient and ED revenues for hospitals; these impacts will vary based on how the hospitals may repurpose space and/or create new service lines that generate additional revenue streams.
- New primary care and other services will be created that are not currently reimbursed or are under-funded by Medicaid. This will cause short-term financial needs until payments evolve into a value-based method.
- As certain services are eliminated or reduced and new services introduced, necessary transitions in workforce, space use, and other costs will be incurred in the short-term and will require temporary support until the new service lines are established and financially sustainable on their own.
- For projects focused on integrating behavioral health services with primary care services, transition costs associated with staff training, adapting to EHR systems, and new work flows could impact productivity will need temporary financial support.
- Primary care providers who will be transitioning to NCQA certified Patient Centered Medical Homes (PCMHs) will experience short-term operational and financial pressures during the conversion, including the loss of provider productivity and lost revenues, which will need to be supported in the interim.
- Other: 1) Short-term cash flow needs for providers experiencing reductions in operating revenues from other NYS health reform initiatives will exist until the provider restructures itself, including cash flow payment lags between current payment streams and those paid through DSRIP incentive payments. 2) Delays in a provider reducing services and/or operating expenses during the implementation of DSRIP projects.

All providers within the PPS will experience a transition in operations as they work towards achieving DSRIP goals. As a result, many will not be able to achieve cost-efficiencies during the initial period, which can put them at some financial risk while carrying out DSRIP objectives. For those who are financially fragile, RCHC will set aside funds to support their pathway to financial sustainability. In addition, funds have been allocated to support lost revenue and enabling/supportive costs to assist with some of the DSRIP transition activities until such requirements are embodied in a new value-based payment model. Access to these funds will be governed by a formal application/budget process to be approved by the Finance Governance Committee and then the Executive Governing Body.

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.

The Refuah Community Health Collaborative (RCHC) Finance Work Group will develop a Financial Sustainability Plan (FSP) during January 2015 which will then be presented to the Executive Governing Body for approval in February 2015. At minimum, the FSP will

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include the following components:
- Key financial/operating metrics with benchmarks for RCHC's partners to comply with, including attainment and improvement targets
- Key metrics and milestones, by project and DSRIP Year, for RCHC to satisfy in order for RCHC to remain financially stable and attain the DSRIP goals
- Management reporting process and timetable for comparing actual versus projected metrics/milestones at both the PPS and partner levels
- Ongoing monitoring of PPS partners' financial sustainability throughout the DSRIP project period
- Application process for distribution of funds from the Sustainability Pool along with budget versus actual reporting of the use of this pool of funds
- Specific reporting/monitoring of financially fragile providers identified during the initial PPS assessment process that require oversight with a restructuring/sustainability plan

There are no currently known restructuring efforts required for partners within RCHC's partner network. RCHC hospital partner, Good Samaritan Hospital, participated in a HEAL NY grant bed reduction program over the past 6 years, reducing certified/in-service beds from 370 to 286 and reconfiguring units to be more efficient. Current occupancy levels are at their highest and they continue to see growth in demand. Through DSRIP, RCHC and its partners will increase the use of community-based resources, which will better manage the growing demand for inpatient care. Reductions in avoidable hospital use will be offset by projected new hospital use due to population growth.

***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.

One of the responsibilities of RCHC's Project Management Office will be to execute the FSP approved by the Executive Governing Body. Annual assessments will be made of all partners within the PPS to monitor financial and operational metrics against benchmarks to assure partners remain financially stable. For those partners whom have been identified as financially fragile, their performance will be monitored and reported on a more regular basis (e.g., monthly, quarterly) depending on the severity of their financial condition. Such reports will be shared with the Finance Governance Committee as required. Financially fragile partners reporting negative trends will be asked to develop a Performance Improvement Plan (PIP) to define their pathway to sustainability.

RCHC's funds flow allows for financially fragile partners to access resources to assist with their pathway to financial sustainability. RCHC partners that require access to these funds will be required to complete a PIP and funding request, which will go through an approval process of both the Finance Governance Committee and then, if approved, the Executive Governing Body.

***Path 3:**

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

RCHC has identified 3 MCOs in its region that account for over 90% of the Medicaid lives and has reached out to the MCO with a majority of the lives to discuss value-based payments. The other 2 MCOs will be contacted in the first quarter of 2015. The current concept is to develop alternative payment models to pay for new services that are not currently covered by Medicaid but drive down the total health care spend (e.g., community-based services) and the implementation of surplus-sharing arrangements to assist with covering lost revenues created by this delivery system reform. As DSRIP will no doubt impact other patient populations aside from Medicaid, the intent is to reach out to other commercial payers to explore value-based payment models as well to bring additional resources to bear to sustain the DSRIP outcomes.

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

Description:

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

***Strategy 1:**

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

The Refuah Community Health Collaborative's (RCHC) Lead Entity, Refuah Health Center, has a long-standing relationship with Fidelis Care, the largest Medicaid MCO in RCHC's region and NYS, and has been operating under primary care capitation arrangements as well as incentive payment programs for many years. In addition, several of RCHC's partners participate in surplus sharing arrangements as well as the Medicare Shared Savings Program.

RCHC's strategy for value-based payment will evolve over the DSRIP project period but is grounded in four major concepts.
1. The system must reward high performers who achieve the desired outcomes.
2. The model must be transparent so providers understand how payment rewards behaviors.
3. The payments must be reasonable and distributed among all provider types who impact outcomes to ensure sustainability.
4. The payment program should be flexible to allow for phased implementation and account for the various phases of payment reform readiness among PPS partners.

RCHC has performed an MCO penetration analysis and has identified 3 Medicaid MCOs in the region that account for more than 90% of the Medicaid managed care lives in the region, with Fidelis Care representing over 50% of the membership. RCHC has commenced meetings with Fidelis Care to discuss a transition to value-based payment and are eager to move forward with such discussions as RCHC puts more structure to proposed models.

***Strategy 2:**

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

Payment reform will include redistributing funds to the providers who drive performance as well ensure a financially stable network. The effects of DSRIP will cause financial stress on hospitals and other inpatient providers through revenue reductions. To sustain these vital providers, DSRIP incentive payments will initially be needed to sustain operations until shared savings can be used to assist these providers with their transformation. Likewise, new innovative costs will be incurred to improve health outcomes and drive down the total cost of care. The new value-based payment system must continue to incentivize these behaviors/services to continue DSRIP's accomplishments and sustain the financially fragile safety net providers.

Given the state of readiness of most of RCHC's partner network, full-risk global capitation is likely not a near-term option. Instead, RCHC is considering a composite value-based payment approach that would be implemented over time as DSRIP projects are implemented and factor in episodic and continuous care bundles of services.

Since RCHC's network comprises several advanced primary care practices and PCMHs, a PCMH-focused payment model with capitation for primary care and PCMH services coupled with a shared savings arrangement for achieving quality measures and driving down the total cost of care for assigned members is a logical short-term goal. In addition, given the strong maternal and child health care practices with RCHC, a value-based payment model around prenatal and maternity care bundle is another early goal. As DSRIP progresses, RCHC will explore other value-based payment models for certain chronic conditions, episodes of care, and subpopulation health management. RCHC understands there may be several value-based payment options with some form of partial capitation for bundled services with a shared savings arrangement for driving down the total cost of care. RCHC anticipates engaging in certain shared savings arrangements (upside only) by DY 3 with an evolution to additional value-based payments in the out years with the goal of moving towards risk-sharing arrangements (both upside and downside risk) in DY5 for the appropriate bundles.

Section 9.4 - Domain 1 – Financial Sustainability Plan Milestones:

Description:

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

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- 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.

Refuah Health Center (RHC) has over 25 years' experience serving diverse Medicaid populations and has implemented multiple population health management systems. RHC uses Cognos, a system that analyzes EHR data and generates "gaps in care" reports. The system enables RHC to monitor population health and ensure appropriate outreach and care. RHC has developed notification systems with hospitals for inpatient admissions and with local EMS providers for ED transfers. RHC operates five mobile medical vans that bring healthcare directly to patients at schools, summer camps, and work sites. In response to an assessment of patient access barriers, RHC developed a free transportation system for families that, for cultural, economic or geographic reasons, do not have access to cars or public transportation. RHC's four shuttles make more than 40 regular stops per hour throughout Rockland County. RHC worked with Fidelis Care to assess preventable utilization and costs in key clinical cost areas (e.g., ED, pharmacy, outpatient diagnostics, specialty care, behavioral health, inpatient care, etc.) and adopted an improved model of care for its Medicaid managed care patients, including opening an Urgent Care to reduce avoidable ED and inpatient utilization and a Wellness Center that is integrated with primary care and supports primary and secondary prevention for patients with or at risk for chronic conditions. The success of this data-driven approach to improving population health outcomes and reducing preventable utilization enables RHC to replicate their successful model among PPS partners to improve population health outcomes in their service area.

RCHC also will collaborate with the 2 other Mid-Hudson PPSs collaborative on population health approaches. This will include training as well as HIT/HIE systems. HIT/HIE systems will include key population health functions (e.g., risk stratification, shared patient care plans, care management, health disparities analyses, etc.).

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

The Refuah Community Health Collaborative (RCHC) has identified the 1199 Training and Employment Fund (TEF) as a training vendor who can provide assistance to the PPS. TEF is the largest joint labor-management workforce planning organization in the US. During implementation planning, TEF has the capabilities to assist RCHC in conducting a comprehensive workforce assessment and identifying new roles, job descriptions, specific skills, and credentials needed. TEF has the resources to conduct multiple trainings that focus on engaging the healthcare workforce in transformation and training them on advanced models of care (e.g., interdisciplinary care teams, care management and coordination, home care, care navigators, community health workers, etc.) so they have the skills to fulfill project requirements and improve outcomes. TEF provides support for recruitment and labor-management relations and can leverage state workforce programs.

RCHC's Executive Governing Body will maintain oversight of TEF. Oversight will include monitoring collaboration among the vendor, governance committees, the workforce workgroup, and the other 2 PPSs in the region to assess and align workforce strategy to clinical/patient needs, aggregate demand for training, and avoid duplication of effort. Training will be conducted by expert clinical staff, experienced educators in adult learning theory and organizational development experts. TEF uses the City University of New York wherever possible to deliver training programs that offer college credit or where workforce and certificate programs meet industry needs.

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TEF screens, assesses, recommends, and contracts, as needed, with other training vendors.

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

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

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SECTION 11 – ATTESTATION:

Attestation:

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

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

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

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

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

Primary Lead Provider Name: REFUAH HEALTH CENTER INC
Secondary Lead Provider Name:

Lead Representative:	Michal Sperka
Submission Date:	12/22/2014 03:25 PM

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