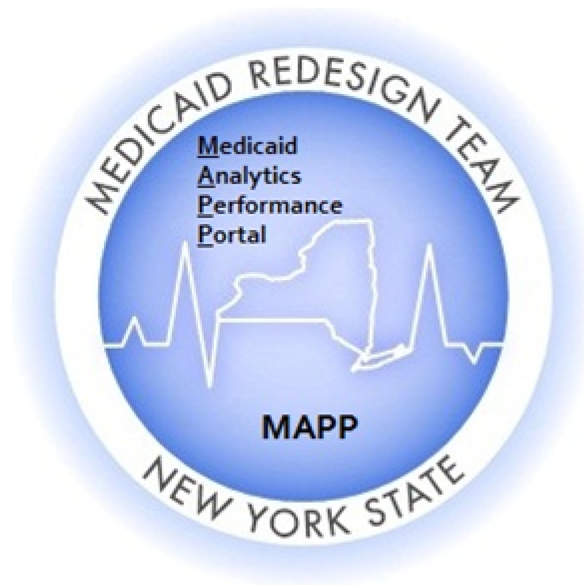
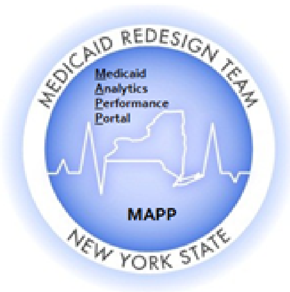
New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP PPS Organizational Application



Samaritan Medical Center



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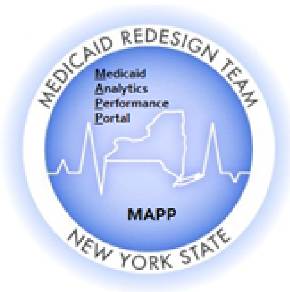

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Samaritan Medical Center (PPS ID:45)

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: **45_SEC000_NCI Samaritan Lead Financial Stability Test.pdf**

Description of File

NCI Samaritan Lead Financial Stability Test

File Uploaded By: hsanchez
File Uploaded On: 12/20/2014 02:37 PM

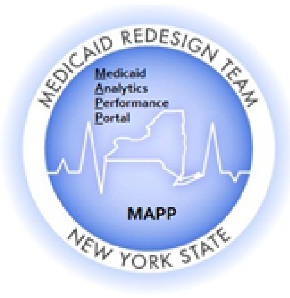
You can use the links above or in the navigation bar to navigate within the application. Section 4 **will not be unlocked** until the Community Needs Assessment in Section 3 is completed.

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: hsanchez
Last Updated On: 12/22/2014 03:11 PM

Certified By:	tc306529	Unlocked By:	
Certified On:	12/22/2014 03:16 PM	Unlocked On:	
Lead Representative:	Thomas H Carman		



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.

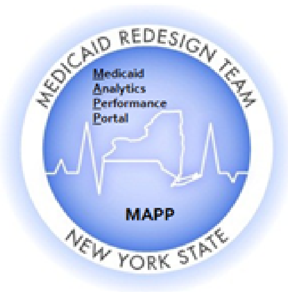
Scoring Process:

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	Implement system-wide clinical interoperability HIT including EMR, HIE and disease registry	System Transformation cannot happen without the ability to rapidly share information between clinical providers. Effective population health management requires the ability to provide feedback and incentive providers and risk stratify patients for interventions
2	Improve access to primary and preventive care	The region has a significant primary care, dental, and BH shortage. Community based prevention services like DPP and tobacco cessation are not covered services these contribute to very high avoidable ER and hospitalization rates. PC and dental providers must be recruited and prevention must be covered.
3	100% of Primary Care Provider achieve PCMH 2014	Primary care is the cornerstone for preventing avoidable hospitalizations and future disease. PCMH 2014 requires open access, care management, quality measurement and other changes that ensure that PC delivers on the prevention promise
4	Improved clinical quality as defined by PQIs and HEDIS for Diabetes, Cardiac & COPD	There is a heavy disease burden of diabetes, cardiovascular and COPD across the region. PQIs for avoidable ER and Hospitalization exceed NYS in every single composite
5	25% reduction in avoidable ER rate	The region has an elevated avoidable ER visit rate for attributed Medicaid beneficiaries and this is in alignment with NYS DSRIP objective
6	25% reduction in avoidable admission rate	The region has an elevated avoidable admission rate for attributed Medicaid beneficiaries and this is in alignment with NYS DSRIP objective
7	Integration of PC and BH care at 100% of participating safety net provider	Mental illness is the single largest cause of hospitalizations and emergency department visits in the region. The suicide rate is nearly twice the NYS rate and the binge drinking rate is significantly higher than NYS. Co-location creates access and recognizes both the illness and the physical effects of the illness/medications
8	Increase care management and care coordination	There is need to risk stratify patients and engage them in varying levels of intensity of care coordination/care management based on their degree of risk.
9	Improved linkages through standardized protocols	Protocols for care transitions between all settings is needed. Disconnects exits across the entire delivery system and even more so between the health care delivery system and the community based services
10	Engage and activate LU, MU and uninsured	There is a population across the region that are not accessing healthcare services at the prevention level and do not engage with the system until they have a disease or end up at the emergency room
11	Improved patient experience	Health literacy and cultural competency is needed for working with low socioeconomic populations in the region to improve the experience of care. Improved access to care when and where it is needed will also impact the



#	Goal	Reason For Goal
		patients experience of care.
12	Engage with MCOs to move to value-base payment system through payment reform	To sustain the system transformation undertaken through DSRIP will require a comprehensive payer strategy

***Formulation:**

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

The PPS has formulated a delegated governance structure that allows for broad representation and input while maintaining clinical leadership. Partner selection for participation in the PPS was driven by the community needs assessment, which puts emphasis on behavioral health, primary prevention, health home, FQHC, hospice, community based advocacy organizations and other providers of social service supports for fragile populations in addition to the hospitals and long term care providers. The PPS's primary care leadership brings the focus of care back to the prevention level with a clear understanding of the care coordination needed to support their patients in prevention efforts outside the clinical walls. The NCI model requires a multi-disciplinary, highly collaborative approach to increase access, improve clinical consistency and quality, and adopt more efficient delivery models that will meet the patient where they are and bring about real success.

***Steps:**

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

In five years, NCI will transform from a highly fragmented system focused on inpatient care to an integrated patient-centered community-based delivery system. The system will move from provider focused to patient focused; from reactive to disease to pro-active for health with incentives aligned with improved patient outcomes. Safety Net providers will operate in a high quality, financially sustainable integrated delivery system. Patients will report a high degree of satisfaction with their care and improved quality of life. The NCI healthcare system, and health record system, will recognize that minds and bodies are connected and treat patients as a sum of their parts, and not in parts. The people of the region will not only be healthier because they have access to preventive care, but happier because they are treated with dignity and respect; when patients leave the physician's office they will feel comforted not confused. In five years public and private payers, healthcare providers, and community based organizations will be partners and colleagues working under value-based payments toward a common goal to ensure that each patient receives the right care at the right time.

***Regulatory Relief:**

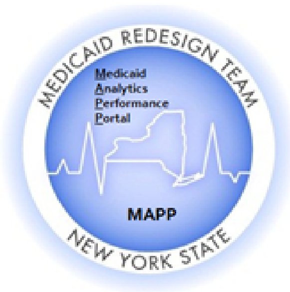
Is the PPS applying for regulatory relief as part of this application? Yes

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

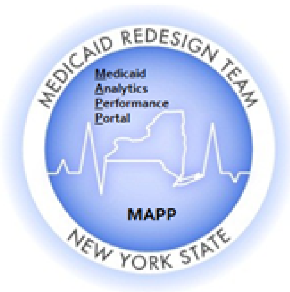
- Identify the regulation that the PPS would like waived (please include specific citation);
- Identify the project or projects in the Project Plan for which a regulatory waiver is being requested and outline the components of the various project(s) that are impacted;
- Set forth the reasons for the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

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

#	Regulatory Relief(RR)	RR Response
1	Article 29F and Proposed Regulations	(1) 2.a.i is implicated and it is a general concern regarding the PPS



#	Regulatory Relief(RR)	RR Response
		program. 2.a.i project requirements (9-10) are implicated because negotiating with private entities increases anti-trust risk. (2) There are ongoing anti-trust concerns for the PPS. NCI requests that the proposed regulations be adopted so that COPA can be applied for. The waiver would facilitate implementation of an integrated system by providing certainty as to the activities that the PPS may undertake without state action. (3) The PPS considered waiting for COPA, but due to the requirements of working with Medicaid MCOs, at the outset, the PPS felt the need for immediate clarity. (4) All PPS activities will be to improve the quality of patient care, improve the patients' experience of care and reduce the costs of care as identified by DSRIP, these activities do not directly implicate patient safety.
2	10 NYCRR 405.1(c)	(1) The integrated delivery system of 2.a.i is generally implicated, but project requirement 10 is specifically implicated. (2) The PPS requests a waiver because the PPS will adopt certain policies on behalf of PPS Partners and will make certain decisions regarding the provision of healthcare to patients in the PPS. The PPS should be specifically exempted from this requirement because its activities with PPS Partners will not rise to the level of operating Partner facilities. The requirement for establishment would be overly burdensome and will delay the timely formation of the PPS. (3) The PPS considered requesting an expedited establishment review, but it was rejected because the activities of the PPS should be deemed to fall below the establishment threshold. (4) Patient safety will not be impacted because the PPS will not be responsible for the day to day operation of any partner and the partners' established operator will still need to formally adopt any policies any make decisions regarding patient care. In addition, any policies pertaining to patient safety could be reviewed by applicable agencies.
3	10 NYCRR 600.9(c)	(1) 2.a.i is implicated and it is a general concern regarding the PPS program. (2) The PPS and its Partners and Affiliates will receive certain distributions of funds pursuant to the DSRIP program that could be construed as fee splitting. The PPS requests a waiver of the requirement that an entity that splits fees needs to have establishment approval. (3) There are no feasible alternatives. (4) Patient safety will not be impacted because the PPS will not be responsible for the day to day operation of any partner and the partners' established operator will still need to formally adopt any policies and make decisions regarding patient care.
4	Public Health Law § 18(6); Mental Hygiene Law § 33.13(c); Education Law 6530(23), Article 32 Privacy	(1) 2.a.i. project requirements (4-7); 2.a.ii. project requirements (4-6); 2.a.iv. project requirements (4-6); 2.b.vi. project requirement (4-7); 2.d.i. project requirement 17; 3.a.i. project requirement 4; 3.b.i. project requirement (2, 8, and 11); 3.a.iv. project requirement 9; 3.g.i. project requirement 6; and 4.b.ii project requirement 4. (2) Without a regulation PPS Partners and Affiliates will be subject to lawsuits from patients regarding uses and disclosures of healthcare information. The PPS requests that a regulation be promulgated that allows the PPS to obtain a single consent for treatment, payment, and healthcare operations uses and disclosures to settle liability under New York law. The regulation could specifically cite the DOH consent form being developed. (3) The PPS could utilize the consent form that DOH is drafting; however, without the issue addressed in binding law there will be outstanding liability questions with regard to inter-PPS disclosures. (4) Patient safety and patient privacy would not be implicated because the PPS, partners, and affiliates will sign business associate agreements or confidentiality agreements regarding patient information and will utilize any consent form DOH proposes and undertake rigorous auditing procedures.



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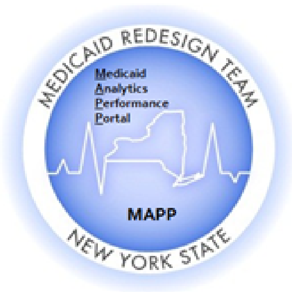
5	10 NYCRR 600.1; Parts 670; Parts 700	(1) All projects. (2) The PPS requests that DOH, OMH, and OASIS create an integrated program for review of Public Need and Financial Feasibility for all PPS projects requiring CON or Prior Approval Review because requiring multiple agency review will make implementing the projects slower and more expensive. (3) The PPS considered complying with current requirements for review by each applicable agency, but feels that multiple agency review will delay implementation of the project. (4) Patient safety will not be implicated because a single agency or integrated review will still have significant oversight over the project.
6	Request for Bi-Weekly Video Conferences to accommodate necessary approvals	(1) All projects. (2) The PPS requests that the Public Health and Health Planning Council schedule a bi-weekly videoconference meeting to accommodate required approvals emanating from approved PPSs. The PPS requests that the Behavioral Health Services Advisory Council schedule a monthly videoconference meeting to accommodate required approvals emanating from approved PPSs. (3) No, due to volume this seems necessary. (4) Patient safety will not be implicated because the review is accelerated not eliminated.
7	10 NYCRR 708.3(e); 10 NYCRR 708.4; 10 NYCRR 710.1(c)(4)(iv); 10 NYCRR 710.1(c)(5)(iv)	(1) 2.a.iv. project requirement 1. All projects involving bed and service relocations between Partners. (2) The PPS requests an accelerated review requirement for bed and service relocations between PPS Partners. The bed and service relocations should only require letter notification to DOH and the review should be deemed to occur after 15 days. There is authority for this in 10 NYCRR 710.1(c)(4)(iv) which allows for certain changes to be made without an application and for limited review under 10 NYCRR 710.1(c)(5)(iv). The 180 day review period in 10 NYCRR 708.3(e) could be shortened to 15 days. This requires eliminating the specific 10 NYCRR 708.4(a) review criteria and substituting whether the relocations fit into the PPS's overall plan. (3) No, due to volume this seems necessary. (4) Patient safety will not be implicated because the review is accelerated not eliminated.
8	10 NYCRR 401.3(g)	(1) If 2.a.i. is successful it will reduce the overall number of patients being admitted as inpatients. This may cause certain facilities or components of facilities to close. (2) The PPS requests that the 90-day timeline for DOH to consider facility or component closure be reduced to 30 days to facilitate timely closures where it is necessary due to the PPS achieving its goals. (3) Utilizing a longer period was considered; however, due to the amount of change in the delivery of healthcare that DSRIP will bring about, closing a facility quickly in order to more efficiently allocate resources may be necessary. (4) Patient safety will not be impacted because the PPS has an effective governance structure with multiple providers that will have analyzed the closure within regional committees and, with all interests and effected parties involved, undertaken a medically sound, open, and deliberative approach to ensuring that services have been effectively moved to other facilities.
9	Education Law §§ 6512, 6513, 6509(9), 6509-a.	(1) 2.a.i. and all projects dealing with creating an integrated delivery system. (2) The PPS requests that a regulation be promulgated clarifying that the activities of a PPS would not constitute the practice of medicine. In particular, the PPS requests clarification that the creation of a single system of credentialing within the PPS does not constitute the corporate practice of medicine.



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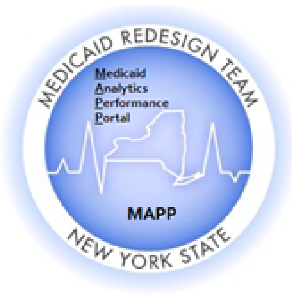
		(3) The PPS considered applying for and may apply for ACO licensure, but the activities of the PPS may not rise to the level of ACO activities immediately because it may not seek out capitated payment arrangements at the PPS level for a number of years. (4) Patient safety will not be impacted because the PPS has an effective governance structure with multiple providers that will be overseen by DOH and other agencies.
10	10 NYCRR § 401.3(a)	(1) 2.a.i. project requirements (4-7); 2.a.ii. project requirements (4-6); 2.a.iv. project requirements (4-6); 2.b.vi. project requirement (4-7);2c.i. project requirements (6-7) 2.d.i. project requirement 19; 3.a.i. project requirement 4; 3.b.i. project requirement (2-5); and 4.b.ii project requirement 4. (2) The PPS requests a waiver to forgo prior review, regardless of cost, for acquisition, installation, and modification, and any capital outlay associated with purchase of EHR for PPS Partners. (3) The PPS considered going through the application process, but feels it would delay the reorganization of EHR within the PPS. (4) This provision does not pertain to patient safety.
11	10 NYCRR §§ 710.1(2), 710.1(3)(i)(q), 710.1(5)(iv)(g).	(1) 2.a.i. project requirements (4-7); 2.a.ii. project requirements (4-6); 2.a.iv. project requirements (4-6); 2.b.vi. project requirement (4-7);2c.i. project requirements (6-7) 2.d.i. project requirement 19; 3.a.i. project requirement 4; 3.b.i. project requirement (2-5); and 4.b.ii project requirement 4. (2) All of these project require use of HIT technologies and interoperability, this will require investment in new EHR technologies, capital and vendor services. The waiver is necessary so that the PPS and all partners do not need further review or approval from the Department regarding HIT acquisition, installation, modification or outlay of capital to implement necessary technology advances to participate in DSRIP project. (3) No alternatives were identified. To facilitate rapid implementation in DSRIP Y1, all partners and NCI must be in a position to make rapid changes in HIT. (4) This provision does not pertain to patient safety.
12	Scope of practice	(1) All Projects dealing with integration of services will face scope of practice issues. (2) The PPS requests that DOH exercise its authority to formally approve each PPS and its treating partners in order to become exempted from these scope of practice provisions for the professions of: Social Work (Education Law, Article 154), Psychology (Education Law, Article, 153), Mental Health Practitioners (Education Law, Article 163). The authority for this is Section 9 of Chapter 420 of the Laws of 2002, as amended by chapter 132 of the laws of 2010, relating to the profession of social work; Subdivision a. of Section 17-a of chapter 676 of the laws of 2002, as amended by chapters 130 and 132 of the laws of 2010, and as further amended by chapter 57 of the laws of 2013, in relation to the profession of psychology and the four professions described as mental health practitioners. The PPS also requests the extension of this scope of practice exemption beyond its July 1, 2016 sunset date. (3) There are no other feasible solutions. (4) The PPS and Partners will develop protocols for practitioner treatment of patients. These protocols and policies could be submitted to DOH for comment.
13	10 NYCRR 600.2	(1) All projects that plan to utilize the integrated outpatient services regulations. (2) The PPS requests in numerous locations that DOH adopt the proposed integrated outpatient services regulations so that the PPS can adopt those



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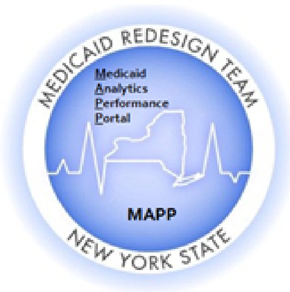
		regulations. In the interim, the PPS requests that for all projects where it has indicated a desire to utilize these regulations DOH grant an waiver or approval under 10 NYCRR 600.2 to allow the PPS to begin the process of undertaking the selected projects in the interim in situations where primary care services will be provided at a facility licensed by OASAS or OMH. (3) If the regulations are not finalized before the implementation of the project begins, then it will be difficult to begin the project without this waiver. The delay to the project of multiple licensure will be difficult. (4) Patient safety would not be implicated because this would merely be a temporary waiver until the project is approved under the integrated outpatient services regulations.
14	10 NYCRR 405.19 (g) (2,5 (b)); 10 NYCRR 710.1(c)(2) or (3)	(1) All projects that plan to utilize observation beds. (2) The PPS requests a waiver to increase number of observation beds and a waiver physical space and location and Construction requirements for those beds regardless of cost. The PPS will comply with the applicable provisions of Parts 711 and 712-2 and section 712-2.4 of this Title for construction projects approved or completed after January 1, 2011. (3) The PPS does not believe there are alternatives to this proposed waiver. (4) The PPS does not believe that this poses a patient safety concern.
15	10 NYCRR 400.9 (c)(1) and (d).	(1) All projects that are impacted are by the use of telemedicine to make decisions about transferring residents from SNFs when physicians, nurses and other clinical staff with the necessary training to make the transfer decision are not available. (2) 10 NYCRR 400.9(c)(1) requires the personal, alternate or staff physician requests or agrees to the admission, transfer or discharge from a skilled nursing facility. The reasons for the waiver request is to allow transfer decisions to be evaluated in a timely way by health care professionals with the necessary expertise to facilitate transfers as needed, and avoid preventable transfers undertaken because of the unavailability of health care professionals at the SNF to evaluate the resident and make a transfer decision by utilizing tele-health and telemedicine services. (3) The PPS does not believe that there are feasible alternatives. (4) Information that supports why the cited regulatory provision does not pertain to patient safety and why a waiver of the regulation(s) would not risk patient safety is that telemedicine will be used to assure that physicians with necessary credentials and training will be consulted regarding the transfer decision in consultation with nursing home staff to assure that the physician has access to available clinical information to inform the transfer decision.
16	10 NYCRR § 98-1.5(b)(6)(vii)	(1) 2.a.i. project requirement 8; 2.d.i. project requirements 6 and 10; 3.a.ii project requirement 3. (2) The PPS will contract with Medicaid Managed Care Organizations as an integrated system and establish value based payment arrangements. This could require licensure as an IPA under 10 NYCRR 98-1.5(b)(6)(7). The PPS requests a waiver of the restriction on MCOs contracting with unlicensed entities for IPA services and recognize that the PPS may perform some IPA services. The PPS requests that it be exempt from the definition of an IPA under 10 NYCRR 98-1.2 (w). (3) The PPS considered seeking IPA licensure, but feels that IPA licensure is inappropriate for a PPS which performs a wide variety of non-IPA services. (4) Patient safety will not be impacted because the PPS is a highly regulated entity where multiple providers with healthcare expertise will be involved in establishing policies to focused on maintaining and improving quality of care in the PPS. DOH could impose certain requirements on the MCO contracts.
17	Public Health Law § 4901(9)(c)	(1) 2.a.i. project requirement 9. (2) The PPS requests that regulations be promulgated indicating that the PPS is not a utilization review agent due to the Public Health Law §



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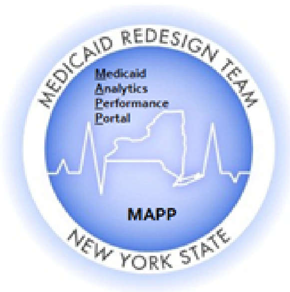
#	Regulatory Relief(RR)	RR Response
		4901(9)(c) exception. The Public Health Law provides that agents acting on behalf of the state and local government for services provided pursuant to title XIX of the federal social security act are not utilization review agents. The PPS will be analyzing utilization and medical necessity of various treatments, especially inpatient hospitalization, and could be deemed a utilization review agent. (3) The PPS considered simply adopting a literal reading of the exception and deeming itself exempt, but feels clarity is necessary given the mission of reducing avoidable hospital use by 25%. (4) Patient safety will not be impacted short term because the PPS will not be making utilization determinations for the MCO immediately and long term safety will not be impacted because the PPS will be changing the utilization model to provide care in other locations. The PPS could provide DOH for comment and retroactive approval its policies regarding medical necessity determinations.
18	Public Health Law § 18(6);Mental Hygiene Law § 33.13(c);Education Law § 6530(23);Article 32 Privacy	(1) 2.a.i. project requirement 11; 2.d.i. project requirements 11 and 13; 4.a.iii project requirement 4 the PPS intends to share PPS data elements gathered from across the PPS with trainers in MEB health promotion. (2) It would be a treatment purposes disclosure for the PPS to disclose information to healthcare providers within the PPS. However, it is not a treatment purposes disclosure to disclose information to engage patients in the integrated delivery system through outreach. As such, the consent form DOH is currently drafting needs to be a HIPAA compliant "authorization" for these activities. The consent form should only need to be obtained once to allow the PPS to conduct all activities required under the project plans. However, an authorization needs to be specific as to the entity the information is to be released to. Therefore, DOH will need to consult with CMS in drafting the authorization to determine if reference in the consent to an online list of PPS Partners and Affiliates will be sufficient for an authorization. (3) There do not appear to be other feasible options. (4) The PPS does not see this as a patient safety issue and to address any safety concerns the PPS would suggest that the DOH consent form contain a location for the PPS to insert a web address listing all Partners and Affiliates to whom the patient is authorizing MEB related disclosures.
19	10 NYCRR §§ 405.2(e)(3), 405.4(b)(4), 94(b)(2-3)	(1) 2.a.ii project requirement 8 dealing with behavioral health screening protocols. (2) The PPS requests that providers be allowed to be credentialed to conduct the BH screenings at the PPS level. Effective PPS preventative care screening will require providers with appropriate credentials to be available in facilities that do not currently credential providers for BH screenings. This will enable the creation of a single community wide practitioner base and waiver of these various state agency requirements. Administrative delays relating to multiple credentialing processes of the State and MCOs can impede a PPS's ability to provide access to care. (3) The PPS considered training all providers on the regulatory screening tools, but doing so would impose an undue administrative burden on the PPS due to cross disciplinary care approach of the PPS and an increased emphasis on behavioral health screening. Additionally, the PPS considered entering into contractual arrangements to serve as a credentialing agent for each entity, but that would create an administrative burden of negotiating numerous contracts. (4) The PPS does recognize that there are patient safety concerns in credentialing. As such it suggests that DOH, OMH, and OASIS could provide a combined list of elements for valid PPS wide credentialing that the PPS must include in its protocols. In the alternative, the PPS could submit its credentialing policies to a combined review team with representatives of DOH, OMH, and OASIS for comment and retroactive approval.

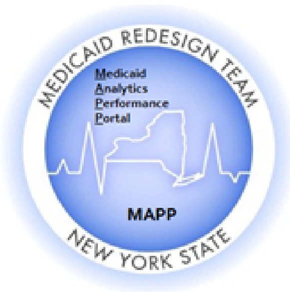


New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP PPS Organizational Application

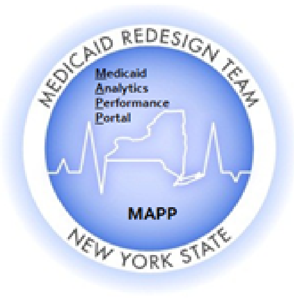
Samaritan Medical Center (PPS ID:45)

#	Regulatory Relief(RR)	RR Response
20	10 NYCRR § 710.1(c)(1-5,7) - add or change method of service	(1) 2.a.iv project requirement 1. (2) The PPS requests a waiver of the requirements of department approval of changes to the extent and kind of services to be provided at PPS Partner Article 28 facilities. The PPS requests a waiver of the factors for determining public need and the specific review process. The PPS requests a waiver of the requirement determination of public need and prior review and approval. The PPS requests that such approval be deemed granted upon review and approval of this application and any supplemental filings regarding specific projects. This is necessary in order to convert outdated and unneeded hospital infrastructure and programs into other types of hospital based programs within a medical village. The process of applying for department approval would be time consuming especially given the number of requests within the next several years. (3) There were no feasible alternatives. (4) The PPS does not see a patient safety concern because all decisions will be made deliberatively by experts in regional health care delivery and will be supported by the Community Needs Assessment data.
21	10 NYCRR §§ 401.3(e), 670.1 (a-b), 710.1(c)(1)(v). - add or reduce bed capacity	(1) 2.a.iv project requirement 1. (2) The PPS requests waiver of need for new CON and need methodology for determination of public need and prior review and approval of decreases in bed capacity. The PPS proposes that approval of the DSRIP Project application be deemed approval of any bed reduction contained therein. However, the PPS requests that if prior review is required only that DOH only require letter notification going forward. (3) There were no feasible alternatives. (4) The PPS does not see a patient safety concern because all decisions will be made deliberatively by experts in regional health care delivery and will be supported by the Community Needs Assessment data.
22	10 NYCRR 401.3(g) - reduce or eliminate a service	(1) 2.a.iv project requirement 1. (2) The PPS requests that DOH reduce the notice period of 401.3(g) from 90 to 30 days. The reduced period will address the need to rapidly change and reconfigure services. This is necessary to allow changes to healthcare delivery in a timely fashion due to the high volume of such requests throughout the state. (3) There were no feasible alternatives. (4) The PPS does not see a patient safety concern because all decisions will be made deliberatively by experts in regional health care delivery and will be supported by the Community Needs Assessment data.
23	Propose Regulations on Telehealth and Telemedicine	The PPS requests that DOH finalize the proposed telehealth and telemedicine regulations.
24	10 NYCRR 401.3 (a)(1-3) and 710.1 (b) (c)(1-5, 7) - Change physical plant	(1) 2.a.iv project requirement 1 for each Medical Village utilizing PC and BH integration; 3.a.i. – North Country Family Health Center integration with Community Clinic of Jefferson County, North Country Family Health Center integration with Transitional Living Services, Community Health Center of the North Country Ogdensburg expansion, Community Services and Claxton Hepburn Article 28 Primary care co-locations. (2) The PPS requests that DOH grant a waiver of the requirement for determinations of public need and prior review and approval for construction projects contained in the DSRIP Project application. To the extent review is deemed necessary, the PPS requests that DOH only require limited review or architectural review only. (3) There are no feasible alternatives due to volume of applications. (4) The PPS does not feel that this regulation is a patient safety regulation.
25	10 NYCRR §§ 710.7(b-c) 710.7 (d) - Expedited Construction	1) 2.a.iv project requirement 1 for each Medical Village utilizing PC and BH integration; 3.a.i. – North Country Family Health Center integration with Community Clinic of Jefferson County, North Country Family Health Center integration with Transitional Living Services, Community Health Center of the North Country Ogdensburg expansion, Community Services and Claxton Hepburn Article 28 Primary care co-locations

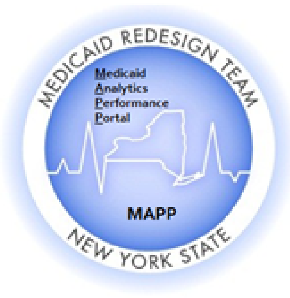


#	Regulatory Relief(RR)	RR Response
		(2) The PPS requests that a waiver of the requirement that DOH advise the PPS in writing that it can commence construction under 10 NYCRR 710.7 (d) and instead deem the submission under section 710.7(b-c) of the regulations complete after 15 days. This is necessary to ensure the ability to rapidly commence construction and renovation projects within the 3 year implementation period for DSRIP. (3) There were no feasible alternatives. (4) The PPS does not feel that this regulation is a patient safety regulation.
26	10 NYCRR 710.9 - Waive pre-opening inspection	(1) 2.a.iv project requirement 1 for each Medical Village utilizing PC and BH integration; 3.a.i. – North Country Family Health Center integration with Community Clinic of Jefferson County, North Country Family Health Center integration with Transitional Living Services, Community Health Center of the North Country Ogdensburg expansion, Community Services and Claxton Hepburn Article 28 Primary care co-locations (2) The PPS requests that DOH expedite the pre-opening inspection and survey to within 15 days and allow the facility to remain open while non-patient areas are under review. This is necessary to ensure the ability to rapidly begin operation once renovation and building projects are complete. (3) There were no feasible alternatives. (4) The review process by DOH of this application will include patient safety requirements to be achieved.
27	10 NYCRR 703.6 - Construction Standards of Part Time Clinic	(1) 2.a.iv project requirement 1 for each Medical Village utilizing PC and BH integration; 3.a.i. – North Country Family Health Center integration with Community Clinic of Jefferson County, North Country Family Health Center integration with Transitional Living Services, Community Services and Claxton Hepburn Article 28 Primary care co-locations (2) The PPS requests that DOH treat extension clinics and diagnostic and treatment centers as a part time clinics under 10 NYCRR 710.6 for purposes of review the construction and operating standards for each project. The waiver is necessary to aid the PPS during the transition phase. (3) There were no feasible alternatives. (4) The PPS recognizes that DOH may have patient safety concerns. As a result, the PPS requests that this be a time limited waiver simply to allow transition to diagnostic and treatment center and extension clinic standards for new integrated clinics.
28	Petition to CMS regarding co-location	The PPS requests that DOH petition CMS to allow DOH to waive CMS colocation requirements when it is deemed in the best interests of promoting the objectives of DSRIP.
29	14 NYCRR § 599-1 - Proposed Integrated Services Center Regulations	(1) 3.a.i. – Samaritan Medical Center will integrate behavioral health into seven hub PCP practices, Carthage Area hospital at 1 hub site, River hospital at one site, Claxton Hepburn at 1 site and Massena Memorial at 1 site; 3.a.i project requirement 2. (2) The PPS intends to utilize the proposed integrated outpatient services center regulations once those regulations are promulgated. The PPS requests that those regulations be finalized as soon as possible. The PPS requests that approval of this application be deemed approval of the integrated services center application under 14 NYCRR § 599-1.15(f). In the alternative, the PPS requests that any multiple agency reviews be consolidated into a single review process to expedite the authorization for this project. (3) No alternatives are feasible for this project. (4) Patient safety will not be impacted due to compliance with the proposed regulations.
30	10 NYCRR 401.2 (b)	(1) 3.a.i North Country Family Health Center will provide primary care services to patients at Community Clinic of Jefferson County and Transitional Living Services. (2) The PPS requests a waiver of the limitation that an operating certificate only permits activities on one site and requests that NCFHC, a licensed

#	Regulatory Relief(RR)	RR Response
		Article 28 FQHC, be allowed to send primary care physicians to CCJC and TLS sites. This is necessary in order to ensure the smooth integration of primary care physicians working in Article 28 hospitals and extension clinics into the Behavioral Health context. (3) No alternatives are feasible for this project. (4) Patient care will not be impacted because NCFHC will remain responsible for adequately credentialing its providers.
31	14 NYCRR 587.4 (7)	(1) 3.a.i North Country Family Health Center will provide primary care services to patients at Children's Clinic of Jefferson County and Transitional Living Services. (2) 14 NYCRR 587.4 (7) defines a provider of service as an entity that is responsible for operation of a program. The remainder of that part imposes certain requirements on providers of services for the operation of outpatient programs. The PPS requests a waiver of the definition of a provider of service to exclude primary care practices, like NCFHC, from complying with the requirements of that subpart applicable to providers of services when co-located with a licensed provider of services. (3) The responsibilities of a provider of services could be split between the co-located institutions, but due to the limited responsibilities of NCFHC for the primary care component at that location BH this would be inappropriate. (4) This will not affect patient safety.
32	10 NYCRR 405.9 (b)(2)	1) The Projects requested for: 2biv to permit providers to implement PPS-approved protocols for care transitions and care pathways, protocols to manage patients in appropriate settings and implement project goals to reduce ED and inpatient hospital usage. 2) The regulation requested for waiver is 10 NYCRR 405.9 (b)(2). 3) There are not alternatives to this request since the source of patient is a factor in identifying patients who may be included in certain programs. 4)To reduce the patient safety concern, clinical governance will include competent professionals to ensure that protocols are safe and appropriate and staff will be trained to focus on patient safety and Quality. Outcomes will be closely monitored to ensure that implementation does not have an adverse impact on patient care.
33	10 NYCRR 405.9 (f)(7)	The regulation requested for waiver is 10 NYCRR 405.9 (f) (7). The Projects requested for: 2biv to permit providers to implement PPS-approved protocols for care transitions and care pathways, protocols to manage patients in appropriate settings and implement project goals to discharge patients to the appropriate post-acute setting. There are not alternatives to this request since the source of patient is a factor in identifying patients who may be included in certain programs. To reduce the patient safety concern, clinical governance will include competent professionals to ensure that protocols are safe and appropriate and staff will be trained to focus on patient safety and Quality. Outcomes will be closely monitored to ensure that implementation does not have an adverse impact on patient care.
34	10 NYCRR 405.9 (f)(3)(ii)	The regulation requested for waiver is 10 NYCRR 405.9 (f) (7). The Projects requested for: 2biv to permit providers to implement PPS-approved protocols for care transitions and care pathways, protocols to manage patients in appropriate settings and implement project goals to discharge patients to the appropriate post-acute setting. There are not alternatives to this request since the source of patient is a factor in identifying patients who may be included in certain programs. To reduce the patient safety concern, clinical governance will include competent professionals to ensure that protocols are safe and appropriate and staff will be trained to focus on patient safety and Quality. Outcomes will be closely monitored to ensure that implementation does not have an adverse impact on patient care.
35	18 NYCRR Section 505.10(c)(2)	(1) 2.a.i Health Home Care managers are an integral component of the IDS and as a key component of their role to insure that beneficiaries have access to the community-based services to remain out of the ER and inpatient admissions.



#	Regulatory Relief(RR)	RR Response
		(2) The PPS requests a waiver of the limitation that restricts transport to pharmacy and preventive services such as the Diabetes Prevention Program and tobacco cessation sites or to access nutrition. This is necessary in order to ensure the that high –risk Medicaid health home patients have access to preventive services. (3) No alternatives are feasible for this project. (4) Patient care will be improved as patients have access to community based supportive services.
36	18 NYCRR Section 505.10(c)(2)	1) 2.a.i Health Home Care managers are an integral component of the IDS and as a key component of their role to insure that beneficiaries have access to the community-based services to remain out of the ER and inpatient admissions. (2) The PPS requests the department to approve and include Health Home care managers as "other type of medical practitioner approved by the Department" as allowed under the regulation (3) No alternatives are feasible for this project. (4) Patient care will be improved as patients have access to community based supportive services
37	10NYCRR Part 760	(1) 2.a.i Timely and available Home Care is a critical component of the Integrate Delivery System to insure patients are well managed in the outpatient setting. At this time there is only one CHHA serving Lewis County. Providers report difficulty finding home care services for their discharged patients following joint replacement and other inpatient releases. (2) The PPS requests a waiver to allow those CHHAs already licensed to provide services in the other counties of the Tug Hill Seaway region to extend the geographic service are to include Lewis County. (3) There is no alternative as a single CHHA cannot adequately cover surges in home care service needs in any county. (4) Patient care will be improved as patients have access to community based supportive services



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.

The North Country Initiative, LLC is a hospital capitalized, physician led Limited Liability Corporation operating with a Delegated Model of governance. The North Country Initiative was originally formed in 2011 as a collaboration of hospitals and independent physicians who realized that change in the regions healthcare delivery system was needed. This group of forward thinking and engaged physicians and healthcare executives determined to create a vision and chart a new course for clinical care and for health in the region. The North Country Initiative partnering hospitals and physician leadership went through an intensive planning process in 2012 and 2013 and have evolved into the existing governance on the basis of collaboration and trust focused on improving the regional healthcare delivery system. NCI has a robust history of success with implementing change, demonstrated through regional project implementation in areas like quality improvements, IT advancement, and physician engagement. The executive governance body of the NCI is a representative Board of Managers which holds accountability for all aspects of Finance, Clinical, Compliance and IT governance. Through this model, transitions in governance structure have been realized which include adding behavioral health providers and community members to the Board of Managers expanding the committee structure to include the DSRIP Project Advisory Committee in a direct advisory capacity to the board

and adding DSRIP goals and deliverables to each of the governance committee's responsibilities.

NCI governance includes committees responsible for clinical, financial, information technology and data sharing and compliance governance. This governance structure is critical to the success of the NCI PPS DSRIP deliverables as well as a recently accepted ACO under the MSSP program and the actively developing Clinically Integrated Network (CIN) program to work with commercial payer's to improve quality metrics and reduce costs. The speed and efficiency of the model of governance created by the NCI will be critical to DSRP success. This governance has demonstrated that it is well-integrated, high functioning and prepared to implement new care delivery models and lead meaningful change on behalf of the people we serve.

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: **45_SEC021_North Country Initiative Organizational Structure.pdf**

Description of File

North Country Initiative Organizational Structure

File Uploaded By: hsanchez

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***Structure 2:**

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

North Country Initiative's governance started as a steering committee focused on the vision and the path forward for this region's healthcare transformation, over the past year it has evolved into the board of managers comprised of 24 members. The class of members was separated into the following three classes:

Class A: 10 physicians (including independent, and community based OMH behavioral health)
Class B: 10 Hospital representatives (includes 5 physicians)
Class C: 4 members, one is a community member, one is a provider of behavioral health services, one FQHC clinical psychologist and one nurse practitioners.

The board of managers provides direction and oversight, with ultimate decision-making responsibility for the DSRIP program. The board of managers has a reporting committee structure tasked to focus on project specific criteria and a Project Advisory Committee (PAC) which consists of 24 members representing the different segments of the regions healthcare and the three representative unions which serves in a direct advisory role to the board on the DSRP program.

The NCI committees are IT governance, Medical Management (clinical), Finance/Contracting, and Compliance, all of which report directly to the Board of Managers. Reporting to the medical management committee are subcommittees focused on the achievement of specific DSRIP deliverables. These include; behavioral health integration sub-committee, population health initiative subcommittee, and a care coordination subcommittee. Reporting to the Compliance Committee is the Cultural Competency and Health Literacy Committee which was formed to ensure that processes, policies and training are incorporated into the governance structure of the NCI.

Each of these sub-committees were developed deliberately to support the projects selected as part of the application. The projects chosen directly address the community's needs addressed in the community needs assessment, as well as the other fundamental requirements. All of these committees are formed and functional. Each sub-committee has created a project charter and are meeting regularly with report outs to the committees, the PAC and/or board of managers. This structure is designed to ensure responsive, focused governance to deliver DSRIP outcomes.

***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 North Country Initiative medical management governance committee will have the largest responsibility in regards to our regions projects. In an effort to place responsibility of progress in the appropriate areas, sub-committees have been created. Strategically these projects have been segmented into three sub committees. Care Transitions subcommittee, Behavioral Health Integration sub-committee, and Population Health subcommittee. The Medical Management Committee will also hold specific responsibility for 3.b.i, and 3.c.i. The medical management committee has been meeting regularly to standardize protocols for DSRIP and has selected clinical pathways and evidence based national guidelines for; Hypertension, Diabetes, and Cardiovascular disease; risk stratification models for high risk patients; and, behavioral health screening (SBIRT and PHQ9). In addition to the ongoing work of monitoring and researching evidence based medicine, this committee will be responsible to monitor and ensure that the clinical goals and initiatives are being realized. In an effort to assist the medical management committee, project advisory committee, and ultimately the board of managers to guarantee our PPS realizes clinical outcomes and goals, a disease registry will be utilized to provide per provider quality reporting. It will receive data from electronic health records and will be utilized to create a comprehensive dashboard for real-time monitoring of performance against DSRIP quality measures. The aggregated data will provide the PPS physicians and partners with timely feedback of their performance and give them the information they need to deliver proactive, comprehensive, and collaborative patient care and will provide the Medical Management Committee and board with the means to monitor for accountability and achievement of improvements tied to incentives.

***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.

NCI, is committed to and fully believes in the current governance structure. Throughout multiple projects this governance structure has proven to be effective. With that being understood NCI also realizes that within the changes of the healthcare system there will be a time that the NCI may have to alter the current system. NCI is committed to the vision of DSRIP and the goal of changing the healthcare system within our region, the governance structure was created to be a fluent body of change in order to be a highly performing organization. The governance structure is created to act on and respond effectively to the regions issues and NCI will maintain that level of responsiveness. One example of change will be realized first quarter of next year, during the planning process the PAC was a direct report to the board of managers with five committees reporting to them. This has evolved as we move into the next phase to an advisory committee of the board meeting quarterly and the sub-committees are integrating into the full NCI Committee structure. This transition will allow NCI to meet the goals of DSRIP, while evolving into a fully functional clinically integrated network and maintaining management of our MSSP ACO within the region. The DSRIP program provides this region an exceptional opportunity to have robust positive impact on our Medicaid population and serves as an opportunity to develop scalable and sustainable processes that will truly transform us from a healthcare system to a system for health. The NCI organizational structure is designed to manage growing healthcare organizational complexity and laying the foundation for a highly performing integrated delivery system.

Section 2.2 - Governing Processes:

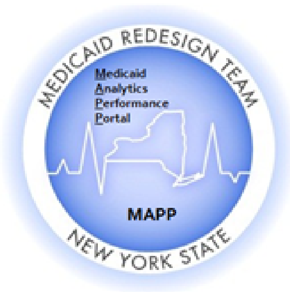
Description:

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

***Process 1:**

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

Collins Kellogg, MD: Board Chairman, Medical Management Committee
Gary Hart, MD: Board Vice Chairman, Chair of Finance Committee
Steve Lyndaker, MD: Board Medical Director, Chair of Medical Management Committee
Michael Seidman, MD: Board Compliance Officer, Chair of the Compliance Committee
David Rechlin, DO: Board Secretary, Chair of the IT Governance Committee
Ben Moore: Board Treasurer, Finance Committee
Jason White, MD: Assistant Treasurer, Finance Committee
Rich Duvall: Board Member
Lauren Roman, MD: Board Member, Compliance Committee
Jack Rush, MD: Board Member, IT Governance Committee
Thomas Carman: Board Member, Finance Committee



Robert Seamon, MD: Board Member
Howard Meny, MD: Board Member, Medical Management Committee
Mario Victoria, MD: Board Member, Medical Management Committee
John Carthy, MD: Board Member
Nate Howell: Board Member, Finance Committee
Mark Parshall, MD: Board Member
Alfredo Torrees, MD: Board Member, Medical Management Committee
Michael Woznicki, MD: Board Member
Dan Mitchell, PsyD: Board Member, IT Governance Committee
Michael Wainberg, MD: Board Member
Jeffery Perrine, NP: Board Member
Angela Doe LMHC: Board Member
John Slattery Community Rep

***Process 2:**

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

North Country Initiative's board of managers has 24 members representing behavioral health, primary care, specialty care, community based programs, and hospitals. Two years ago many of these individuals came together as the NCI Steering Committee. The board of managers was officially formed earlier this year when North Country Initiative became a legal entity with operationing and participation agreements created and signed by the members. There were three main goals in the selection criteria for the board. First, NCI needed to be led by physicians and clinical providers. NCI realizes that physician/clinical leadership is key to the success of healthcare transformation. Secondly, NCI wanted to assure all three counties were represented. Third, the board needed representation from the many different segments of healthcare. Currently the NCI organizational agreement has three classes of membership that encompass the board of managers. Class A are both the independent, and hospital employed physicians. Class B members represent hospital administrators and hospital physician leaders. Class C membership is made up of NP's, PA's and Behavioral Health providers. The members of the PAC who serve in the governance structure were selected by area of expertise, geographic coverage and community partner representation (detailed later in this application). The Committee structure and members were selected based on knowledge set and ability to impact achievement of outcomes/deliverables.

***Process 3:**

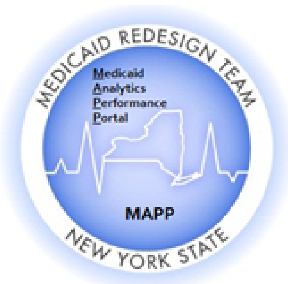
Please explain how the selected members provide sufficient representation with respect to all of the providers and community organizations included within the PPS network.

NCI is respected across the region for its physician leadership, ability to accomplish goals and leadership in healthcare transformation. One reason for this success is how well the leadership of NCI represents the many different segments of healthcare in the region. Another comes from NCI's willingness to work with all groups, and accept feedback, advice and constructive criticism from PPS partners. The board of managers has representation from Primary and Specialty care, Behavioral health, Community Based Orgs, Hospitals and the Community. Committee selections like the board have representation from the 3 counties served. In addition the PAC has representation across all sectors and sub-committees encompass the regions health and community resources poised to serve the population. It is of note that the sub-committees and PAC voted unanimously for the NCI board of managers to be the decision making body for the DSRIP due to the trust that has been built over time in this region.

***Process 4:**

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

Five of the safety net hospitals serve on the Board of Managers along with their physicians, as does one of the two FQHCs, two of the largest safety net behavioral health providers in the region and multiple participating independent physicians. The PAC is cross representative of all of the partners in the region and the DSRIP sub-committees are made up of those partners that are participating in, carrying out and informing the projects. NCI's strategy is to utilize existing partner expertise and not grow new services. The PPS intends to contract with partner community based organizations for care management, community health workers, project 11 navigation, the diabetes prevention program (DPP), tobacco cessation, and cultural competency and health literacy assistance.



***Process 5:**

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

The NCI board of managers has committed from its inception to a one member one vote policy. No matter how big or small the organization represented each vote counts the same. NCI is built on trust and collaboration to help sustain a healthy partnership into the future. Currently and for the foreseeable future NCI has held themselves to that standard. All the hospitals and physicians on the board regardless of market volume, bed count, net revenue etc. has the same equal vote of one. NCI guiding principles regarding voting are, a quorum must be present from each of the classes of members and a majority vote of that quorum present. Accepting the invitation to be part of the Board of Managers came with the understanding that the changes and initiatives the region would be undertaking have significant demands of time, analysis, thought and hard decisions that will be assumed by the individual board members. With that understood the NCI board of managers meets regularly, twice a month currently. At each board meeting, the physician led board reviews and discusses the committees work and makes the necessary decisions. As part of these meetings the board has the challenging discussions around the path forward and how this regions healthcare system prepares and adjusts to the new initiatives seen across the country and state. The NCI board of managers is also deeply involved in the funds flow discussions and how to best represent the DSRIP dollars so that the most positive impact comes out of this region for the patients NCI serves. Each decision made adheres to the one member, one vote policy. A mental health counselor from a small behavioral health organization on the board has the same voting power as the CEO of the largest medical center.

***Process 6:**

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

NCI board of managers was created and established on the concepts of trust and collaboration, to date these members have been cohesively working together towards the same vision. Establishing that from the beginning has set up the board to alleviate and minimize conflict. To resolve conflicts that present themselves, NCI has created three classes of members to represent the board. Each class must meet a quorum for there to be a board vote or decision. The vote is from an odd number of individuals which also minimizes conflict. If a conflict continued to be present and the board was unable to resolve on their own the conflict would escalate to the equity owners of North Country Initiative. NCI also realizes the value of knowledgeable legal counsel and has engaged an experience firm to advise on challenging issues. NCI also realizes the value of the Department of Health and their ability to help resolve conflicts and if needed, NCI would seek the consultation of DOH.

***Process 7:**

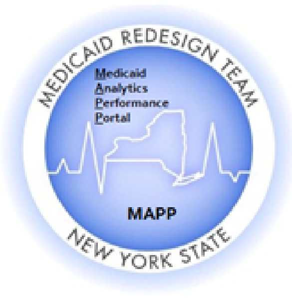
Describe how the PPS governing body will ensure a transparent governing process, such as the methodology used by the governing body to transmit the outcomes of meetings.

North Country Initiative was built around trust and collaboration. Trust has been earned due to transparency and openness of sharing information, vision and the progress towards meeting the goals of the initiative. This guiding principle will carry into DSRIP. NCI currently has a public SharePoint site where all meetings and meeting materials are located. NCI distributes a weekly DSRIP "5 Fast Facts" that links to materials on the SharePoint site as they are developed. At this time NCI is in the process of creating a website where we will publically share DSRIP information that has been discussed, and voted on at the Board of Managers and committee meetings. In addition, it is the goal of NCI to significantly improve patient engagement, within NCI's website we will provide education, resources and information about how the NCI is making care more accessible, the positive changes that are occurring and how patients and the community can obtain materials and provide feedback.

***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.

Communication and openness with the regions stakeholders and patients will be one of the keys to NCI's success. Stakeholders and advocates are serving on committees and the PAC to ensure engagement throughout the process. NCI DSRIP materials are posted to the website and open to the public. At all times stakeholders will be able to visit the NCI website and see the documents and progress of DSRIP. Public education campaigns are being planned that inform of the work this region is doing. Surveys and public forums will be used to communicate the initiative, to answer the questions and to evaluate our regions performance from the beneficiaries' perspective. NCI will seek means to enable our partners to engage two way communications with their patients around the regions progress and the goals of DSRIP.



Section 2.3 - Project Advisory Committee:

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

***Committee 1:**
Describe how the Project Advisory Committee (PAC) was formed, the timing of when it was formed and its membership.

The Project Advisory Committee was formed in September of 2014 during the planning process after the award of the planning grants. The Initial PAC meeting was October 1, 2014 where they developed a charter and set a bi-weekly meeting schedule. The composition of the PAC was is based on the guidance provided by NYSDOH regarding specific roles to be engaged. The PAC includes primary care, chronic disease specialty and psychiatric physicians from the NCI board of managers and organizational representation by knowledge area from each health sector and by geographic location and union representation from each union serving the NCI PPS organizations, and representation representing the broad classes of workers that will be engaged in the PPS. Subcommittees/workgroups and cross functional teams worked through the planning elements for the project iniatives. These workgroups included representatives who serve on the PAC and reported out to the PAC as well as planning and technical staff who provided support and resources to both the workgroups and the PAC.

The PAC members and their roles are: Aileen Martin, Northern Regional Center for Independent Living, (Advocacy); Joey Marie Horton, North Country Family Health Center (FQHC); Ann Richey, Community Health Center of the NC (FQHC); Kathy Hunter, Union – SEIU 1199; Angela Doe, St. Lawrence County Community Services (LGU-OMH); Kim Honeywell, Union – NYSNA; Barry Brogan, North Country Behavioral Healthcare Network; Laura Eannace, CNY Health Home Network; Debra Bosco, Behavioral Health Worker Rep and supportive housing, Transitional Living Services; Nate Howell, Claxton Hepburn Medical Center; Dr. Mark Parshall, Carthage Area Hospital Primary Care; Randy Fipps, Samaritan Medical Center; Dr. Michael Seidman, Claxton Hepburn Medical Center –Specialty; Rob Seamon, Clifton Fine Hospital; Dr. Michael Woznick, Community Clinic of Jefferson - BH Clinic; Tina Cobb, North Country Prenatal/Perinatal Clinic; Dr. Steven Lyndaker, Lowville Medical Associates - Independent PC; Todd Amo United Helpers - Long Term Care Rep; Ginger Hall, Jeff County Public Health - Home Care Rep; Traci Mintonye, River Hospital; Howie Ganter Jefferson Rehabilitation- OPWDD Rep; Wayne Lincoln, Union – CSEA; James Scordo, Credo Community Center OASAS rep; Zack Chapman, Massena Memorial Hospital.

***Committee 2:**
Outline the role the PAC will serve within the PPS organization.

The PAC will serve as a direct advisory committee to the NCI board of managers. The PAC has met bi-weekly to monthly throughout the planning process, will meet at least monthly during the implementation process and will meet at least quarterly throughout DSRIP year one through DSRIP year five. Once DSRIP year one begins the PAC will be provided with regular updates on the status of project initiatives and engaged to provide recommendations as the plan is implemented. The PAC was selected for their unique knowledge and can provide insight into course corrections and innovations to improve deliverable achievement. The PAC has been a valuable engaged resource throughout the planning process and is expected to continue to serve with that same value throughout DSRIP implementation.

***Committee 3:**
Outline the role of the PAC in the development of the PPS organizational structure, as well as the input the PAC had during the Community Needs Assessment (CNA).

The PAC
The Project Advisory Committee were involved and informed throughout the development of the NCI DSRIP Project Plan. The NCI PAC were called upon to provide feedback on the Community Needs Assessment and on recommended NCI PPS initiatives to the NCI Board of Managers for consideration and adoption. Recommendations must be in-line with the NYS DOH Project Initiatives and guidance for DSRIP.

***Committee 4:**
Please explain how the selected members provide sufficient representation with respect to all of the providers and community organizations included within the PPS network.

The composition of the PAC was is based on the guidance provided by NYSDOH regarding specific roles to be engaged. The PAC includes primary care, chronic disease specialty and psychiatric physicians from the NCI board of managers and organizational representation by knowledge area from each health sector and by geographic location and union representation from each union serving the NCI PPS organizations, and representation representing the broad classes of workers that will be engaged in the PPS. Subcommittees/workgroups and cross functional teams included representatives who serve on the PAC and reported out to the PAC. This composition ensures that all partners are either represented directly on the PAC or through their committees/sectors representation on the PAC.

Section 2.4 – Compliance:

Description:

A PPS must have a compliance plan to ensure proper governance and oversight. Please describe the compliance plan and process the PPS will establish and include in the response the following:

***Compliance 1:**

Identify the designated compliance staff member (this individual must not be legal counsel to the PPS) and describe the individual's organizational relationship to the PPS governing team.

North Country Initiative has appointed Dr Michael Seidman as the Compliance officer. Dr Seidman also sits on the NCI board of managers and has the chair responsibility of the Compliance Committee. Dr Seidman leads a team of compliance officers and physicians whose expertise will be invaluable to the success of the NCI compliance plan. Currently on the compliance committee are 2 physicians, 3 hospital Chief Compliance Officers and legal counsel.

***Compliance 2:**

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

North Country Initiative is fully committed to abiding by all state and federal rules and regulations as well as compliance to the DSRIP program. To meet this commitment a Compliance Committee has been established which is led by our compliance officer. Currently on the compliance committee are 2 physicians, 3 hospital Chief Compliance Officers and legal counsel. To date the compliance committee has meet numerous times to discuss the creation of the compliance plan and training requirements of NCI. The NCI compliance plan will be approved through the board of managers. The compliance officer has a seat on the board of managers and gives a monthly report to the board on progress of the committee and any potential compliance issues. Currently the compliance committee responsibilities are to 1) create compliance plan, review all agreements, contracts and procedures, 2) oversee training requirements, 3) respond immediately to possible compliance issues around operations and performance, 4) review the Compliance reporting hot line that will be established, while reporting monthly to the board on steps to address the report.

***Compliance 3:**

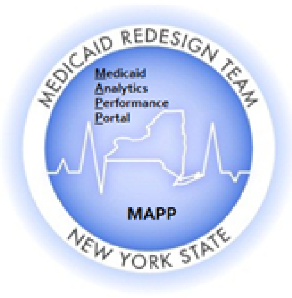
Describe the compliance training for all PPS members and coalition partners. Please distinguish those training programs that are under development versus existing programs.

The NCI compliance officer and committee are finalizing revisions to the NCI compliance plan for board review. The compliance committee is responsible for the development of compliance education and training included in the compliance plan. Training includes anti-trust, anti-kickback statues, non-retaliation policies, conflict of interest policies, data sharing/information security requirements, records retention, HIPAA and audit procedures and is being updated to include DSRIP regulations. Currently the compliance officer and committee are evaluating existing training options within our PPS to see if those programs will meet the needs of NCI's compliance training, or if creation of training programs tailored to the NCI PPS will need to be assumed. It is anticipated that compliance education and training will begin in April of 2015.

***Compliance 4:**

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

Compliance to the DSRIP program, and all state and federal laws is important to the NCI. NCI recognizes the value of providing a forum for compliance issues to be raised by attributed Medicaid beneficiaries and uninsured community. A compliance web-based mailbox will be developed for the anonymous reporting of compliance issues, as well as an open door policy will be highly recommended and



encouraged to be the rule for communication between the members attributed to NCI and their providers. The NCI Compliance Plan includes a compliance officer and a compliance hotline. Medicaid members and their advocates can file a compliance complaint either through the hot line or through a web feedback form. No matter by which means it is received, it will be provided to the Dr. Michael Seidman, the NCI Compliance Officer for review and determination of next steps to bring to the compliance committee. NCI, will accept and encourage all compliance complaints and address each complaint within an appropriate timeframe. It will be the expectation that each complaint is investigated and addressed with the board of managers.

Section 2.5 - PPS Financial Organizational Structure:

Description:

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

***Organization 1:**

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

To assist the North Country Initiative with matters associated with the financial success of the PPS, a finance committee has been created. Currently the NCI finance committee is made up the appropriate stakeholders within the DSRIP program, from CFO's, CEO's, accountants, directors across the PPS. The NCI finance committee is responsible for the development of:

Funds flow policies and procedures
Monitor financial performance of NCI and its partners, while reporting monthly to the board of managers
Create and execute policies around financial accountability and oversight
Report budget issues to the board of managers when the realized budget exceeds the projected budget
Assist in the establishment of pay-for performance and or incentive initiatives
Produce the yearly budget.

To assist the PPS with financial success performance logic a software program is being considered to assist with creating a financial and operational impact analysis.

***Organization 2:**

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

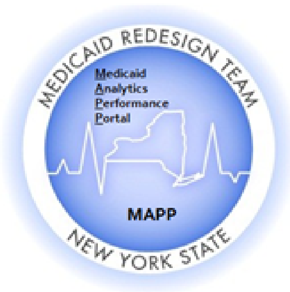
North Country Initiative has three key components to the finance functions, 1) Samaritan Medical Center. 2) The NCI Finance Committee, and 3) a project management office. Samaritan Medical Center, lead applicant and one of the 6 hospitals within the North Country Initiative was unanimously selected to be responsible for the fiduciary requirements and distribution of DSRIP funds. Samaritan Medical Center and NCI have agreed that the NCI will have principle oversight of all financial matters, while reporting all their findings and requests to the board of managers. The finance committee is currently working on the funds flow and 2015 budget. It is the expectation of the finance committee that they will also be responsible to create the financial policies and procedures, which will include but not limited to: spending authorities and limits for the PMO, completion of funds flow and budget, development of annual budgets, and creation of financial metrics and standards.

***Organization 3:**

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

NCI's compliance and finance committee with Board of Managers approval has agreed to an annual risk assessment to be performed that will identify any areas of potential exposure while incorporating any identified risks into an internal and an external audit plan which is subject to approval by the SMC Audit Committee. The external auditors are accountable to the Compliance, Audit and Finance Committee, and the NCI Board of Managers to determine whether financial statements fairly represent the financial results from our operations. Internal audit functions are carried out by the lead entities Corporate Compliance which is accountable to the Compliance and Audit Committee and the Board of Directors. This financial information is the basis of our reporting for Medicare and Medicaid cost reports as well as our IRS form 990.

***Organization 4:**



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

NCI's established compliance committee, is currently working to establish a compliance program in accordance with NYS Social Security Law 363-D that will be led by the compliance officer. NCI Compliance Committee is comprised of the compliance officer, hospital Chief Medical Officers and 3 hospital Chief Compliance Officers. NCI's compliance plan will be in accordance to the New York State Social Security Law 363-D. NCI will utilize the expertise of our PPS partners and lead entity who currently has established Compliance plans that adhere to NYS Social Security Law 363-D.

☑ Section 2.6 – Oversight:

Description:

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

***Oversight 1:**

Describe the process in which the PPS will monitor performance.

NCI, believes that it is critical to evaluate and monitor performance if NCI's PPS to achieve the goals of DSRIP and other initiatives. To fully implement a performance monitoring program there are four measures to be used. 1) NCI will implement and utilize a disease registry population health management tool. The registry will receive data from electronic health records and have the capability to exchange CMS data. This data will be utilized to create a comprehensive dashboard for real-time monitoring of performance against DSRIP quality measures. 2) NYS Medicaid claims database. 3) NCI will also utilize its PPS partners EMR systems and other tools to discuss measures and tracking of their own performance towards the projects they are working on. 4) NCI is currently in discussions with Performance Logic to lease the use of their DSRIP tracker. DSRIP Tracker provides comprehensive project management support and allows for easy tracking and reporting of project progress, with real-time data.

***Oversight 2:**

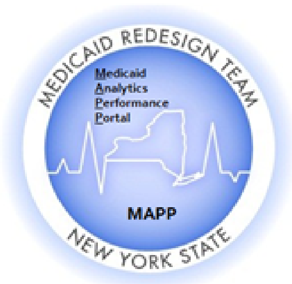
Outline on how the PPS will address lower performing members within the PPS network.

North Country Initiative is dedicated to meeting the must pass quality measures of the DSRIP Program, and in order to meet those stated goals NCI will be providing individual participant reviews and will monitor PPS aggregate data. Clinical participants not meeting goals will receive corrective measures from the Medical Management Committee, non-clinical measures will be monitored by the PAC and Board. NCI will implement a staged remedial course to assist participants to meet goals. Stage 1: Ensure the data source is accurate. Stage 2: Process Optimization: Quality managers, and participants will gauge to see if, the process to capture clinical quality and process measures is working and that all providers are using a standardized method of capturing data. Stage 3: Participant will be responsible to produce a course correction plan and work with the medical management committee and/or board of managers. An incremental plan will be created and used to improve performance. If after all three stages are complete and there is still no improvement in the participant's ability to meet the stated quality and process metrics progressive disciplinary actions will commence.

***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.

NCI, as previously stated will use a 3 stage approach to improve the PPS partner's performance. If after all three stages are complete and there is still no improvement in the participant's ability to meet the stated quality metrics progressive disciplinary actions will commence. If this scenario occurs the responsible committee will create a report to the board of managers that clearly defines the steps taken towards assisting the participant improve his or her performance. This report will be also be given to the participant and the compliance committee. After review and acknowledgement from all appropriate stakeholders the report and the mandatory actions to be completed will be brought to the NCI board of managers for approval. The participant will have the opportunity to be part of the Board meeting that will discuss the mandatory actions to be taken. After approval of the remedial performance plan from the board the participant will have 30 days to enact those changes and report back. If after 90 days of implementing the remedial performance plan there still is no change or progression towards meeting the requirements the responsible committee will prepare a formal recommendation to dismiss the participant. The formal recommendation will be presented to the Board of Managers. If the Board of Managers agrees with the recommendation and has evidence to support the findings a meeting between the Board of Managers and DOH will commence to formally decide and enact the recommendation. NCI recognizes that all of their partners play an integral part in meeting our regions stated goals, with that understanding NCI will do everything they can to avoid removal of its members and will implement as much assistance as the partners are



willing to accept so that all members are successful and have the ability to be part of this regions healthcare transformation.

***Oversight 4:**

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

The NCI Compliance Plan includes a compliance officer and a compliance hotline. Medicaid members and their advocates can provide feedback about providers either through the hot line or through a feedback form that will be developed and provided on the NCI website. No matter by which means it is received, it will be provided to the Dr. Michael Seidman, the NCI Compliance Officer for review and determination of next steps to bring to the compliance committee.

***Oversight 5:**

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

It is anticipated that Medicaid beneficiaries and their advocates will be notified if members are removed through their Managed Care Organizations and/or through their Department of Social Services Case workers. This process will be fully developed during the DSRIP implementation plan development.

☑ 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

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

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 assessment was conducted over a six month period from June 1, 2014 – December 1, 2014. The CNA was developed by defining the target community, engaging diverse stakeholders, and analyzing primary and secondary data. The entire process was designed to give community members and healthcare providers an opportunity to identify and communicate health needs, assets, and barriers for the Tug Hill Seaway Region.

The target community was defined on the basis of geography and insurance status, with specific emphasis on the Medicaid and uninsured populations. As such, stakeholders across the Tug Hill Seaway Region that represent or engage with those unique populations were recruited to develop the assessment. Through an iterative process, stakeholder input was used to inventory resources, identify gaps in the delivery system, prioritize community and resource needs, determine regional assets and inform primary data collection. The process employed 33 focus groups, 2 regional surveys, and numerous community meetings to engage stakeholders and gather input. The assessment also leveraged information that was gathered through stakeholder sessions in 2013 to develop the regional Community Health Assessment.

Secondary data collection and analysis relied heavily on New York State Department of Health DSRIP provided chartbooks, dashboards and databases. After performing a complete review of the data provided by the state, alternative validated data sources were assessed to address any gaps in the analysis. The alternative sources allowed the PPS to characterize population demographics, map the Medicaid and uninsured populations, identify disparate population groups (e.g. Amish groups, migrant workers), and map health care facilities. The information that was gathered from stakeholder engagement, primary and secondary data analysis was vetted by key stakeholders and the Project Advisory Committee (PAC), then used to justify the selection of DSRIP projects.

***Overview 2:**

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

The CNA is a comprehensive assessment of the target population and an analysis of the healthcare and community resources available to serve the population. Quantitative and qualitative information was gathered through stakeholder engagement, primary data analysis and secondary data analysis. The CNA process was data-driven, allowing the PPS to select DSRIP projects that represent the expressed health needs of the community.

Stakeholder engagement, through focus groups, surveys, and community meetings provided the primary data used in the CNA. To identify resource gaps and community health needs, focus groups were held with community members at various locations across the region. Attendees represented the general population, Medicaid beneficiaries, behavioral health stakeholders, healthcare workforce stakeholders,

and population health stakeholders. Two regional surveys were administered: one in 2013 to gauge perceived health needs of the general population, and another in 2014 to gather responses from the target population of Medicaid beneficiaries and uninsured community residents. Each survey had responses from over 1,300 community members and provided feedback from a demographically representative population sample. The community meetings were held at local academic institutions, accessible to the target population.

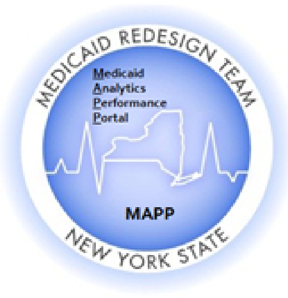
Additionally, the CNA leveraged clinical, outcomes and Medicaid claims data provided by the DSRIP Chartbooks, the DSRIP Dashboards, NYS Statewide Planning and Research Cooperative System (SPARCS), NYS Office of Quality and Patient Safety, and the Centers for Medicare and Medicaid Services (CMS). Community demographics were gathered using data from the U.S. Census Bureau and North Country Health Compass. Information used to analyze the available resources was gathered from the Northern New York Directory of Community Services, NYS Center for Health Workforce Studies, Health Resources and Services Administration and the American Hospital Association.

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	7	6
2	Ambulatory surgical centers	6	5
3	Urgent care centers	8	4
4	Health Homes	2	1
5	Federally qualified health centers	2	2
6	Primary care providers including private, clinics, hospital based including residency programs	194	86
7	Specialty medical providers including private, clinics, hospital based including residency programs	273	132
8	Dental providers including public and private	116	8
9	Rehabilitative services including physical therapy, occupational therapy, and speech therapy, inpatient and community based	16	6
10	Behavioral health resources (including future 1915i providers)	27	26
11	Specialty medical programs such as eating disorders program, autism spectrum early	4	3
12	diagnosis/early intervention	2	2
13	Skilled nursing homes, assisted living facilities	9	7
14	Home care services	12	9
15	Laboratory and radiology services including home care and community access	9	6
16	Specialty developmental disability services	10	6
17	Specialty services providers such as vision care and DME	14	1
18	Pharmacies	8	2
19	Local Health Departments	3	3
20	Managed care organizations	4	0
21	Foster Children Agencies	5	3
22	Area Health Education Centers (AHECs)	1	1



#	Provider Type	Number of Providers (Community)	Number of Providers (PPS Network)
23	Non-Fire Based Ambulance Providers	9	5

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

***Infrastructure 2:**

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

The provider network for the NCI service region is already operationally lean. There is limited excess capacity even at the hospital infrastructure level due to recent conversions to critical access hospital status. There is a substantial need to increase and expand access to quality preventive care, dental and primary care and to integrate behavioral health and primary care. Disconnects exist in the current system across every sector of the care continuum and has the most substantial impact on those with the least access to resources and most significant burden of disease. There is a need to expand provider's knowledge and understanding of the populations they serve. The composition of available providers needs to be modified in the following ways:

Prevention & Quality – The region performs poorly compared to NYS on every single Prevention Quality Indicator. In addition, Medicaid and uninsured indicate the main reason for leaving region for care was quality. Existing providers must modify practice of care to address quality prevention through patient centered medical home (PCMH) and place a strong focus on cardiac, diabetes, COPD and mental illness and substance abuse prevention due to the prevalence of these diseases and the impact on avoidable admissions and emergency room visits.

Care Connections – Standardized protocols and capacity needs to grow for care management/coordination. This includes inpatient to outpatient from physical floors and inpatient mental health units, inpatient to long-term-care, emergency dept to primary care (PC) or outpatient behavioral health care. In addition to inpatient, care connections need to be established between community-based supportive services and PC, between preventive services and PC and between PC and outpatient mental health and alcohol and substance abuse. Medical records access between providers is not standardized. These factors underscore the need to modify the disparate components into an Integrated Delivery System under the regional governance of the North Country Initiative and the need for care transition from inpatient to outpatient, for advanced PC and the integration of PC and BH services and the need to create strong partnerships with the Managed Care Organizations, Health Homes and pharmacies.

Physician Recruitment & Expansion - While care coordination and connectivity with community based services is critical, the most significant immediate modification to meet the needs of the community is an increase in the number of primary care, psychiatry and dental providers in the region. We cannot connect people to primary and preventive care that does not exist. The region has fewer than 74 primary care providers per 100,000 population compared to the NYS rate of 120 and the entire region is a Medicaid Primary Care and Mental Health Provider Shortage Area (HPSA). Due to previous efforts there is a pipeline of social workers that will be entering the market over the next two years so the focus is primarily on physicians and extenders. FQHC expansion is needed in Lewis County and in the City of Ogdensburg. In addition, there is no urgent care center to serve Ogdensburg.

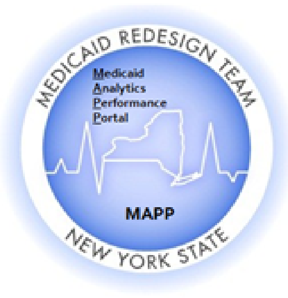
☑ Section 3.3 - Community Resources Supporting PPS Approach:

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.



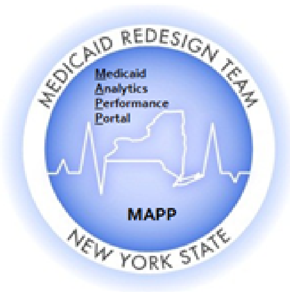
#	Resource Type	Number of Resources (Community)	Number of Resources (PPS Network)
1	Housing services for the homeless population including advocacy groups as well as housing providers	19	14
2	Food banks, community gardens, farmer's markets	58	7
3	Clothing, furniture banks	9	1
4	Specialty educational programs for special needs children (children with intellectual or developmental disabilities or behavioral challenges)	8	7
5	Community outreach agencies	6	4
6	Transportation services	4	1
7	Religious service organizations	4	2
8	Not for profit health and welfare agencies	12	9
9	Specialty community-based and clinical services for individuals with intellectual or developmental disabilities	3	2
10	Peer and Family Mental Health Advocacy Organizations	5	5
11	Self-advocacy and family support organizations and programs for individuals with disabilities	5	5
12	Youth development programs	3	3
13	Libraries with open access computers	21	2
14	Community service organizations	9	2
15	Education	2	2
16	Local public health programs	3	3
17	Local governmental social service programs	3	3
18	Community based health education programs including for health professions/students	5	5
19	Family Support and training	5	5
20	NAMI	1	0
21	Individual Employment Support Services	3	2
22	Peer Supports (Recovery Coaches)	2	2
23	Alternatives to Incarceration	2	1
24	Ryan White Programs	0	0
25	HIV Prevention/Outreach and Social Service Programs	3	3

***Resources 2:**

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

The wide range of community based resources in the region include those that provide services to support basic life needs as well as specialty services such as educational services for high risk children. These organizations support, stabilize and improve the health of the regions fragile populations. The following primary modifications need to be made to support the outcomes of the DSRIP.

Connections: While disconnects exist across every sector of the health care continuum, disconnects between the healthcare system and community resources are even greater. These disconnects have the greatest impact on the most fragile populations, those living with mental illness and substance use disorders, single mothers with children living in poverty, the homeless and those with chronic health conditions. These are the populations the health home is designed to assist yet they are not reaching (8% Health Home baseline engagement rate). It is imperative that protocols be put in place to connect individuals with the health home and to build capacity and capability in the health home services to assist patients to access existing community resources. Care plans must include community-based resources and patients' social and economic context, an individual who has no home, no transportation or no heat will be unable to remain compliant with treatment plans. The resources to help with these issues exist in the community. The missing link is a systematic way to engage these resources. The health home should be that link.



Growth to meet needs: Prevention programs provided by community based resources such as the DPP provided by the YMCA, Public Health and St. Lawrence Health Initiative need to be utilized and will need to grow as systematic referrals are put into place. Peer run organizations that serve those with mental illness like, the Mental Health Association, Step-by-Step and those who serve people with disabilities will take a more active role in engaging those they serve as they become part of care plans along with other supportive services. NAMI will be engaged by the PPS and the PPS will identify why no Ryan White programs currently exist in the region. Homeless housing and supportive housing has recently grown in the region and appears to be meeting needs with the Points North Housing Coalition leading this work and participating in the PPS. This will need to be monitored. Transportation is also an area that will need to be monitored and for which contingency funds may need to be spent if a waiver cannot be attained.

Become Outcome Driven: Community based resources will be in a new position and will need to undergo the same kind of monitoring for outcomes and effectiveness of their services that physicians do for health care. The community resources in the NCI region have been heavily engaged in the planning process and are excited and ready to begin this process.

☑ 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 Medicaid population in the NCI service area has a higher proportion of children under 18 years (32%), than the general population. The majority, over 37%, of the Medicaid beneficiaries in the NCI service area fall within the 18-44 age group. Over 75% of the uninsured population in the NCI service area fall in the 19-54 are range, with the greatest proportion (over 30%) within the 35-54 age group. In the general population, Jefferson County has the lowest median population age at 32.6 years, St. Lawrence County is 37.5 years and Lewis County has the highest, 40.2 years. Of the three counties, Jefferson County has the highest percentage of children under 18 years (24.9%), while Lewis County has the highest percentage of adults over 65 years (16.2%). The age distribution in St. Lawrence County closely matches that of the State average. Conversely, both Jefferson and Lewis Counties have a higher proportion of residents under 18 years, than the State.

***Demographics 2:**

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

The Tug Hill Seaway region has little racial diversity in the total population (92% white), even less in the population of Medicaid beneficiaries (93% white) and slightly more in the uninsured (85.83% white). Jefferson County is the most racially diverse of the counties: 88.8% White and 6.1% Black or African American. Lewis County is the least racially diverse with 97.6% White. The uninsured population has a higher proportion of Black residents, over 8%, likely due to young transient populations near the Fort Drum Army base in Jefferson County and the three large universities in St. Lawrence County.

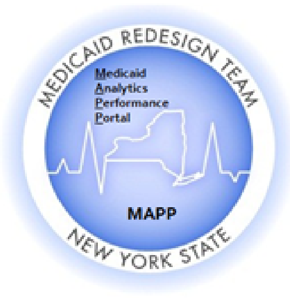
Approximately 91% of the total population is English-speaking. In Lewis County, the English-speaking population exceeds 94%. Less than 3.97% of the region is Spanish-speaking, the most prevalent non-English language. Close to 14% of the population lacks basic prose literacy skills, implying that health literacy limitations exist, especially among the low-income and elderly populations.

***Demographics 3:**

Income levels:

In all three counties, the median household income is at least $11,000 less than the statewide average of $56,951. Income levels across the region range from 73.9%-83.3% of the statewide median. Jefferson County has the highest median household income at $45,559, while St. Lawrence County has the lowest at $43,390. Data from the USDA Economic Research Service indicate that the income levels in Jefferson and Lewis Counties are trending upwards, while the level in St. Lawrence County was less than that of the previous reporting period. The low regional income levels help to explain the observation that approximately 25% of the population is enrolled in Medicaid and more than 10% remain uninsured.

The primary income sources, by industry, are health care for Jefferson (16.84%) and Lewis Counties (14.32%), and educational services



from St. Lawrence County (19.43%).

***Demographics 4:**

Poverty levels:

As expected from the analysis of income levels, the region as a whole significantly exceeds the NYS poverty rate with St. Lawrence County having the highest proportion of persons living below the Federal Poverty Level. Both Jefferson (15.1%) and St. Lawrence (17.6%) Counties have poverty rates that exceed the statewide average (14.5%). The poverty rate in Lewis County is 13.6%, marginally lower than the State average. A similar distribution is observed for children (under 18 years) living below poverty: Jefferson (26.3%), Lewis (20.3%), St. Lawrence (25.0%). The childhood poverty rates in Jefferson and St. Lawrence Counties both exceed the statewide rate of 22.8%.

***Demographics 5:**

Disability levels:

The regional proportion of individuals with disabilities far exceeds the statewide average (10.8%). St. Lawrence County has the highest proportion (14.3%), while Lewis County has the lowest proportion (12.9%). In Jefferson County, 13.3% of the population has a disability. In Jefferson and Lewis Counties, 46.6% of the disabled population is under 65 years old. In St. Lawrence County 49% of the disabled population is under 65. In Jefferson and Lewis Counties over 53% of the disabled population are male, while in St. Lawrence County more than 51% of the disabled population are female. Across the region, the majority of the disabled population had a high school diploma (over 41%), were not in the labor force (over 60%), and spoke only English (over 96%).

***Demographics 6:**

Education levels:

The region has better high school graduation rates and lower high school drop-out rates than the statewide average 84.6% and 2.7%, respectively). Jefferson County has the largest proportion of high school graduates (88.1%), while St. Lawrence County has the lowest (86.4%). St. Lawrence County also has the highest proportion of high school drop outs (2.4%), while Lewis County has the lowest proportion (1.4%).

Regional attainment of Bachelor's degrees is much lower than statewide averages (32.5%). Jefferson County has the largest proportion of Bachelor's degree recipients (20.6%) and Lewis County has the lowest (13.7%).

***Demographics 7:**

Employment levels:

Across the region, unemployment rates exceed the statewide average (8.5%). St. Lawrence County has the highest rate of unemployment at 10.5%, while both Jefferson and Lewis Counties have unemployment rates of 10.1%. In Jefferson County, 11.6% of males are unemployed and 12.6% of females are unemployed. In Lewis County 9.2% of males are unemployed and 4.9% of females are unemployed. In St. Lawrence County, much like Lewis County, there is a greater proportion of unemployed males (12.0%) than unemployed females (9.4%).

***Demographics 8:**

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

There are five medium security correctional facilities in the service area – Watertown, Cape Vincent, Gouverneur, Ogdensburg, and Riverview. Each of these facilities serve the male population, exclusively and have health care services provided on site with the exception of acute services. In addition, each County has county owned jails. In 2012 there were 342 individuals incarcerated in the County owned facilities and in 2013 there were 374. The vast majority of these inmates were males under the age of 50. There are significant needs for these inmates to reintegrate successfully into the community. It is not know exactly how many of the inmates live with mental illness or substance abuse disorders but it is estimated to be high. This is an area that may need to be resourced out of contingency at some point.

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

As necessary, please include relevant attachments supporting the findings.

File Name	Upload Date	Description
45_SEC034_Project 2.a.ii_Question 1_Samaritan Medical Center.docx	12/22/2014 11:03:46 AM	Project 2.a.ii Question 1 Samaritan Medical Center

Section 3.5 - Community Population Health & Identified Health Challenges:

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

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

The regional premature death and preventable hospitalization rates (25.6% and 151.0, respectively) exceed statewide measures (23.9% and 135.6, respectively). The leading causes of death within the region are heart disease, cancer, chronic lower respiratory disease (CLRD), stroke and unintentional injury. In Lewis County, diabetes emerges as a leading cause of death. The leading cause of death for women, by county is heart disease (Jefferson and Lewis Counties), and cancer (St. Lawrence County). For men, the leading cause of death, by county is heart disease (Jefferson and St. Lawrence Counties) and cancer (Lewis County).

The leading causes of primary preventable premature deaths are heart disease, respiratory disease, stroke, diabetes, cancer and suicide. In St. Lawrence County diabetes emerges as a leading cause of premature death. The leading cause of premature death for both men and women in all counties is cancer.

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

The top five causes of Medicaid hospitalizations and emergency room visits for the region are mental illness, cardiovascular disease, respiratory disease, diabetes and substance abuse. Of the beneficiaries with any of these conditions, 38% had a hospitalization and 50% utilized the emergency room in 2012. Mental illness and substance abuse combined (38% of beneficiaries had an admission) and cardiovascular disease (40% of beneficiaries had an admission) account for the leading drivers of inpatient volume.

The Tug Hill Seaway region exceeds the statewide measure on every single adult composite for avoidable hospitalizations including adult overall composite - Tug Hill Seaway 2144 admits per 100,000 compared to 1848 for Statewide. Adult circulatory condition - Tug Hill Seaway 447 compared to Statewide 422. Adult angina without procedure - Tug Hill Seaway 32 compared to Statewide 27. Adult diabetes composite - Tug Hill Seaway 436 compared to Statewide 372. Adult uncontrolled diabetes - Tug Hill Seaway 59 compared to Statewide 46. Adult respiratory conditions composite - Tug Hill Seaway 599 compared to Statewide 500 and COPD - Tug Hill Seaway 1040 compared to Statewide 814.

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

Measures of ambulatory care sensitive conditions, as reported in the Healthcare Effectiveness Data and Information Set (HEDIS), show that screening rates for cervical cancer (59% vs 67%), breast cancer (46% vs 63%), and colorectal cancer (38% vs 49%) for the Medicaid population are all lower than statewide measures. For those with schizophrenia, adherence to antipsychotic medications is lower than statewide measures (60% vs 66%), and diabetes screening for those with schizophrenia or bi-polar disorder are lower that statewide measures (70% vs 79%). Also, well-child visits with the first 15 months are significantly lower than NYS rates. Additionally, the measure for follow-up care within 30 days after a mental illness hospitalization is lower than the statewide measure (47% vs 55%).

These trends are also evident in the general population where only 66.2% of the population receive colorectal cancer screening (statewide 69.3%). Of note, the heart attack hospitalization rate of 20.6 (statewide 15.2) and the adult diabetes short-term complications hospitalization rate of 6.3 (statewide 6.1) underscore the need to treat these conditions effectively in the outpatient setting.

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

Rural residents are more likely to suffer from chronic illnesses that their urban counterparts and this observation is reflected in the statistics for the Tug Hill Seaway Region. The region bears the burden of chronic diseases, namely diabetes, cardiovascular disease, colorectal cancer, COPD and lung/bronchus cancer. The prevalence of these conditions is well defined in the Tug Hill Seaway Region – proportion of adults with diagnosed diabetes is 10.6% (compared to 9.0% statewide); diabetes hospitalization rate for short-term complications is 6.3 (compared to 6.1 statewide); heart attack hospitalization rate is 20.6 (compared to 15.2 statewide); colorectal cancer mortality rate is 18.8 (compared to 15.7 statewide); lung/bronchus cancer mortality rate is 54.9 (compared to 42.8 statewide). There is a homogenous distribution of heart attack hospitalizations across the entire region, with each of the three counties registering a rate higher than the statewide average. Conversely, the prevalence of asthma is lower than statewide rates – asthma emergency department visit rate is 56.8 (compared to 88.6 statewide).

Across the region, the rates of sexually-transmitted infections and HIV are lower than statewide measures. The newly diagnosed HIV case rate is 7.8 (compared to 18.3 statewide), the gonorrhea case rate is 106.5 for women and 56.9 for men (compared to 235.8 and 284.1, respectively statewide), the chlamydia case rate for women is 1223.1 (compared to 1625.1 statewide), and the syphilis case rate is too small to be reported.

For the Tug Hill Seaway Region, mental illness combined with substance abuse are the leading drivers of inpatient volume. 38% of Medicaid beneficiaries with a mental health and substance abuse diagnosis had an inpatient admission. Mental illness diagnoses result in the most avoidable admissions, readmissions and emergency department use for Medicaid beneficiaries rated mental health the number one health issue in their community and substance abuse and tobacco use in the top four health issues in their community along with cancer followed by obesity, diabetes and heart disease. The suicide rates across the region are nearly twice the rate for NYS (13.8 compared to 7.8). There is a homogenous distribution of suicides across the entire region, with each of the three counties registering a rate higher than the statewide average.

***Challenges 5:**

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

The region has reports primarily positive indicators for maternal health. Infant mortality rates are not significantly different than NYS rates, the rate for preterm births and low birth weight babies are below the state averages, and the proportion of exclusively breastfed infants far exceeds the averages for NYS.

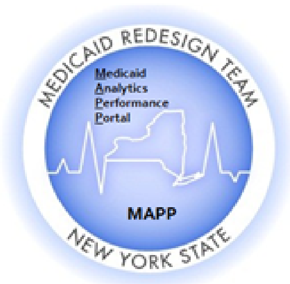
On the negative side, the region's children are not receiving the recommended level of care. Only 48% of children in the region receive the recommended number of well-child visits compared to 69.9% for NYS. This measure is slightly improved for children with Medicaid but still the below state average. Health insurance coverage rates for children (ages 0-19 years) are marginally lower than the state benchmark. In all three counties, the proportion of third-graders with untreated tooth decay far exceeds the statewide measure (over 40% vs a State rate of 24%). Aligned with that observation is the increasing trend of emergency department visits for dental caries. More than 90 children age 3-5 per 10,000 present at the emergency room annually for dental caries. These conditions are exacerbated by dental and primary care provider shortages in the region.

***Challenges 6:**

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

In the Tug Hill Seaway Region, 32.3% of the adult population is obese, compared to the statewide average of 24.9%. The issue also affects the child and adolescent population given the observation that 20.8% of the pediatric population is obese, compared to 17.6% across the State. Adult smoking rates significantly exceeds the state rate (region: 20.2%, NYS: 15.6%), binge drinking (alcohol) rates (region: 24.7%, NYS: 17.8%), and self-inflicted injury rates (region: 8.0, NYS: 5.3) all exceed measures across the State and help to explain the diabetes, cardiac, respiratory disease and suicide rates observed in the region.

Respondents to our 2013 community health needs survey indicated that they wanted to increase their level of physical activity (76%), properly manage their weight (69%), improve their diet (67%), and safely manage stress (58%). Frequently cited barriers to engaging in physical activity included insufficient time, weather, physical inability and financial barriers. Across the region only 20% of the respondents indicated that they simply chose not to exercise.



***Challenges 7:**

Any other challenges:

During both the 2013 community health needs survey and 2014 survey targeting the Medicaid and uninsured population, residents in each county expressed concern regarding access to care, especially in relation to primary care, dental care and mental health treatment. The Tug Hill Seaway Region has been federally designated as a Low-Income Medicaid Health Professional Shortage Area (HPSA). There are significantly fewer active primary care providers (74 compared to 120 NYS), dentists (44 compared to NYS 78) and mental health professionals (Psychiatrists 17 compared to 36 NYS) per 100,000 population, practicing in the Tug Hill Seaway Region than statewide. The Tug Hill Seaway has lower provider rates in virtually every category. Furthermore, the rural environment and high seasonal snowfall averages present significant transportation challenges for individuals attempting to access care within the region.

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 provider network for the NCI service region is already operationally lean. There is limited excess capacity even at the hospital infrastructure level due to recent conversions to critical access hospital status. However through DSRIP there is expected to be a reduction in the utilization of inpatient beds and the conversion of this internal capacity to create Medical Villages that support outpatient services to include integrated behavioral health and primary care services in Watertown, Carthage, Alexandria Bay, and Massena an urgent care center in Ogdensburg where there is a gap in urgent care and access to specialty services through the utilization of telemedicine in Star Lake.

The region until recently was significantly under bedded for long term care and still shows a gap however with the recent development of more assisted and alternatives to institutionalization with Samaritan Summit Village and United Helpers assisted living campus the community is no longer indicating a gap.

The overwhelming gap is primary care. There is not enough primary care, the hours of primary care access are not ideal in all communities, some communities lack access to urgent care, primary care is not available to those with mental illness at their primary location of access. There is not enough access to behavior health services including children's behavioral health services - waiting lists in some cases exceed six months for an intake. The system is not appropriately resourced to serve patients with intensive needs. Care management and care coordination is lacking at almost every point of care. Care transitions from the inpatient to the outpatient setting are not well coordinated. Prevention programs such as the diabetes prevention program (DPP) chronic disease self-management program (CDSMP) and tobacco cessation programs are not covered services and are not receiving referrals. Preventive dental care that accepts the Medicaid benefit is nearly non-existent in the region. There is not a Community Health Worker program to engage high-risk communities to identify and embrace solutions.

While care coordination and connectivity with community based services is critical, the most significant immediate need if the region is to be successful at addressing preventive care for the Medicaid and uninsured population will be to grow the primary care, dental and behavioral health licensed health professional workforce. We cannot connect people to primary care that simply doesn't exist. The NCI must increase primary care, psychiatry and dental capacity. At this time, due to previous efforts there is a significant pipeline of social workers that will be entering the market in the next two years so the focus is primarily on physicians and physician extenders.

***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.

Availability and accessibility - The Tug Hill Seaway Region has been federally designated as a Low-Income Medicaid Health Professional Shortage Area (HPSA). There are significantly fewer active primary care providers (74 compared to 120 NYS), dentists (44 compared to NYS 78) and mental health professionals (Psychiatrists 17 compared to 36 NYS) per 100,000 population, practicing in the Tug Hill

Seaway Region than statewide or upstate New York as illustrated in the table below.

Urgent cares can serve as a bridge between the physician's office and the ED and serve to relieve ED overcrowding. Preliminary research indicates that patients younger than 30 are more likely to use an urgent care than visit their PC. Thus it is important to include urgent care as part of the NCI care continuum. Access to urgent care is being appropriately met across the region with the exception of Ogdensburg. There is no urgent care facility to serve this population center along the St. Lawrence River.

Affordability – Surveyed Medicaid beneficiaries identified finding physicians and dental providers that would accept their insurance as a barrier to care. Additionally, regarding access to mental health services, the entire Medicaid-Eligible populations of Jefferson, Lewis and St. Lawrence Counties all live within Mental Care HSPAs.

Quality - The fact that the region needs more focus on prevention services and quality of care initiative such as the patient centered medical home is highlighted by the fact that the region performs poorly on every single prevention quality indicator (PQI) composite. The Tug Hill Seaway region exceeds the statewide measure on every single adult composite for avoidable hospitalizations including adult overall composite. In addition, both Medicaid beneficiaries and the uninsured surveyed indicated the number one reason for leaving the region for care was quality.

***Gaps 3:**

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

The PPS strategy is focused on three areas accessibility, quality, and coordination:

Accessibility: The PPS will grow primary care, behavioral health and dental capacity by expanding graduate medical education, placing a significant investment of dollars in recruitment strategies and by insuring that practices are resourced to practice at the top of their licensure. The two FQHCs serving the region will expand their service area and capacity. Five of the hospitals and the three largest stand-alone behavioral health providers will co-locates services to integrate primary care and behavioral health services so access to care for both BH and PC are provided at the patients most common point of service. One hospital will add urgent care where none exists. The PPS will cover the cost of prevention services such as the diabetes prevention program, tobacco cessation classes, and telemedical psychiatric consults to primary care providers to ensure access to these community based services for covered Medicaid beneficiaries.

Quality: The PPS will implement patient centered medical home for all primary care practices and place particular emphasis on the standardization and implementation of evidence based protocols for cardiovascular disease, diabetes, COPD and mental illness. The PPS will monitor clinical performance, provide feedback and incentivize positive quality improvement.

Coordination: The PPS will implement care coordination across the continuum including care management at the primary care practices, care transition coordinators at the point of care transition from the acute setting, Health Home care coordination with community based resources, and community navigators to engage the NU/LU and uninsured and community health workers to work with identified high risk "hot spot" communities.

☑ Section 3.7 - Stakeholder & Community Engagement:

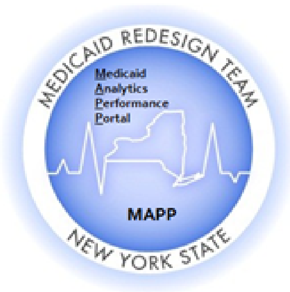
Description:

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

***Community 1:**

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

Community engagement and feedback formed an integral part of the assessment process both in 2013 and for the DSRIP focused 2014 CNA. FDRHPO sought community input through surveys, focus groups with community members, interviews with community stakeholders and communication with over 100 diverse community partners in the prioritization and implementation planning process.



Public health and health care professionals shared knowledge and expertise about health issues. Leaders and representatives of non-profit and community-based organizations provided insight on the community, with specific emphasis on the medically underserved, low income, and minority populations. In addition, multiple interactive presentations have been given across the region to over 30 stakeholder and community groups ranging from community service organizations to Hospital Boards to the Federally Qualified Health Centers to Action Planning Council.

To identify resource gaps and community health needs, focus groups were held with community members at various locations across the region. Attendees represented the general population, Medicaid beneficiaries, behavioral health stakeholders, healthcare workforce stakeholders, and population health stakeholders. Two regional surveys were administered: one in 2013 to gauge perceived health needs of the general population, and another in 2014 to gather responses from the target population of Medicaid beneficiaries and uninsured community residents. Each survey had responses from over 1,300 community members and provided feedback from a demographically representative population sample. The community meetings were held at local academic institutions, accessible to the target population. The entire process was designed to give community members and healthcare providers an opportunity to identify and communicate health needs, assets, and barriers. As such, regional stakeholders that represent or engage with those unique populations were recruited to develop the assessment. Through an iterative process, stakeholder input was used to inventory resources, identify gaps in the delivery system, prioritize community and resource needs, determine regional assets and inform primary data collection. The FDRHPO and North Country Health Compass websites and social media pages were also used to promote stakeholder engagement sessions and report findings.

***Community 2:**

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

During the 2014 DSRIP CNA process, stakeholder engagement took place through multiple stakeholder working and focus groups including. The entire process involved: 4 Workforce focus groups with regional health workforce stakeholders; 12 behavioral health focus groups with regional behavioral health providers; 9 care transitions work groups with hospital and community-based stakeholders; 3 population health focus groups with community-based, primary care and hospital-based stakeholders; 5 physician working group meetings with primary and specialty care clinicians. Additionally, mental health and disability advocacy groups participated in workforce and behavioral health workgroups.

Some workgroups and focus groups were very tailored - either outcome-specific, population-specific or DSRIP project-specific. The population health focus groups were divided into three categories: chronic disease, maternal and child health, or mental health and substance abuse.

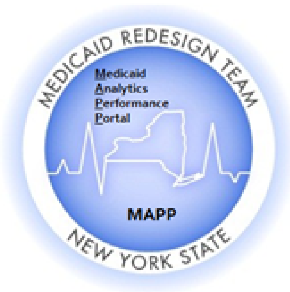
***Community 3:**

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

More than 13% of the Medicaid Beneficiaries and approximately 46% of the uninsured respondents had no usual source of primary care. As expected, uninsured individuals had lower rates of access to both primary care and dental care, with over 60% of the uninsured having no dental visit within the past year and 43.6% having no primary care visit.

Aside from the severity of the complaint, the main reasons offered for accessing the emergency room are linked with low access to primary care and the opening hours of the doctor's office. Migration of services was associated with attempts to access specialty care, primary care, dental care and Ob-Gyn care. These responses underscore the severity of provider shortages within the region, and the community's perceptions of the quality of care within the region. Additionally, several of the observed poor health outcomes can be effectively treated in the outpatient setting, though necessitating increased integration of the delivery system. Though interagency collaboration was identified as a regional asset, there still exists disconnects in the clinical delivery system.

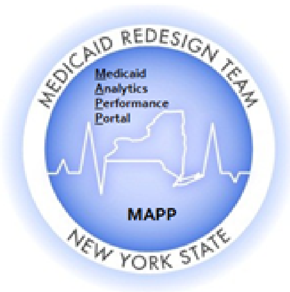
In the chart below, please complete the following stakeholder & community engagement exhibit. Please list the organizations engaged in the development of the PPS strategy, a brief description of each organization, and why each organization is important to the PPS strategy.



Samaritan Medical Center (PPS ID:45)

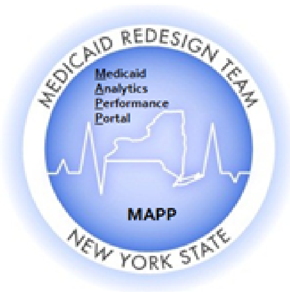
[Samaritan Medical Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
1	Northern Regional Center for Independent Living	A community-based disability rights and resource center that promotes community efforts to end dis-crimination, segregation, and prejudice against people with disabilities, by working with community partners to create an accessible, inclusive society. Through NRCIL, people discover choices to live more independently, with enhanced dignity. Organization belongs to a network of 37 Independent Living Centers in New York State.	The development of an equitable integrated delivery system requires input from a wide range of providers and agencies involved in the spectrum of care. NRCIL's noted history with the disabled population provides valuable insight for the PPS.
2	Community Health Center of the North Country	A Federally Qualified Health Center providing health services to all individuals regardless of ability to pay. Organization serves St. Lawrence and Jefferson counties, with sites located in Canton, Gouverneur and Watertown. Services are site-specific. The St. Lawrence site offers primary care, podiatry, dental care, optometry, physical therapy, psychiatry and counseling, case management. The Jefferson County site offers optometry and podiatry.	FQHC's regularly interface with the target population and have the insight, reach and experience required to assist the PPS to engage and activate low-income residents within the region. They are critical components of the care delivery system, also offering prevention services and playing a vital role in the coordination of care.
3	St. Lawrence County Community Services	County department responsible for the administrative oversight and planning of services in St. Lawrence County for individuals with chemical dependency, mental illness and developmental disabilities.	Mental illness is the single highest cause of preventable inpatient admission and emergency department visit in our region. Substance abuse rates are also high and when surveyed, Medicaid beneficiaries indicated that mental illness was the number one health concern in their community. To effectively address the behavioral health needs of our population the PPS relied on the department of Community Services for their expertise and experience.
4	North Country Behavioral Health Network	A network of behavioral health providers in Northern New York working together to strengthen behavioral health services in the region. Through the network, member organizations are able to share resources and opportunities for education, program advocacy, technology development, best practice dissemination, collaborative funding, and project development and management.	Mental illness is the single highest cause of preventable inpatient admission and emergency department visit in our region. The suicide rate for the region is nearly twice the state rate and Medicaid beneficiaries surveyed indicated that mental illness was the number one health concern in their community. To effectively address the behavioral health needs of our population the PPS relied on their expertise, experience and advocacy.
5	Transitional Living Services	A not-for-profit agency which provides residential services for individuals in need of psychiatric and rehabilitative support who were unable to live independently in the community. Agency provides services to children, adolescents and adults in counties throughout Northern New York; these services include Supported Housing, Adult and Children's Community Residences, Treatment Apartments, Veterans Homeless Demonstration Pilot Program, OMH and OCFS Waiver Services, Supportive Case Management, Jefferson County's	Mental illness is the single highest cause of preventable inpatient admission and emergency department visit in our region. The suicide rate for the region is nearly twice the state rate and Medicaid beneficiaries surveyed indicated that mental illness was the number one health concern in their community. To effectively address the behavioral health needs of our population the



[Samaritan Medical Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		Mobile Crisis, St. Lawrence County Respite and most recently an Advantage After-School Program in Lewis County.	PPS relied on their expertise, experience and advocacy.
6	Carthage Area Hospital	Originally established as a not-for-profit 501 (c)(3) rural community hospital, Carthage Area Hospital is a newly-accredited, 25-bed Critical Access Hospital. The hospital serves approximately 83,000 residents living in Jefferson, northern Lewis and southern St. Lawrence Counties in two capacities; it is a Sole Community Hospital provider and it is one of the largest employers within the community. The CAH Community Partners Primary Healthcare Network works to improve healthcare access to residents within its primary and secondary service area through collaborating partnerships with local governments, schools, churches, civic organizations and neighboring healthcare providers. As a result of these partnerships, the hospital operates twenty three primary/specialty article 15 clinics throughout the region. CAH has also developed partnerships with various schools to open School Based Health Clinics (SBHC) at Carthage Middle and High Schools, most of which have dental and mental health services.	Hospitals are critical partners in the development of an integrated care delivery system and a medical village with strong emphasis on care coordination. Several facilities also provide vital primary care outpatient services and wellness initiatives that will help the PPS to develop a patient-centered system that truly serves the needs of the target population, improves prevention efforts and reduces avoidable hospital use.
7	Claxton-Hepburn Medical Center	Claxton-Hepburn Medical Center is a private, not-for-profit, 130-bed community hospital and regional referral center. Claxton-Hepburn includes 67 acute-care beds, a 10-bed intensive care unit, a 10-bed birthing center, a 28-bed mental health center and a 15-bed acute rehabilitation unit. The Medical Center provides primary care to nearly 40,000 residents of Ogdensburg and surrounding communities and regional services to the 110,000 people of St. Lawrence County. Claxton-Hepburn Medical Center has an active medical staff of more than 50 physicians representing most specialties. Regional and countywide services include radiation and medical oncology, dialysis treatment, wound healing and diagnostic imaging.	Hospitals are critical partners in the development of an integrated care delivery system and a medical village with strong emphasis on care coordination. Several facilities also provide vital primary care outpatient services and wellness initiatives that will help the PPS to develop a patient-centered system that truly serves the needs of the target population, improves prevention efforts and reduces avoidable hospital use.
8	Lowville Medical Associates	A primary care practice offering specialized primary care for the whole family with pediatric and adult internal medicine providers on staff.	This primary care practice has spearheaded several patient-centered initiatives in the region and is recognized by NCQA as a level-3 Patient Centered Medical Home. The expertise of the practice was leveraged to develop strategies to increase the number of PCMH-certified practitioners in the region.
9	Jefferson County Public Health	Local health department providing services in the areas of home care, long-term care, prevention and wellness, communicable disease control, child health, screening, health education, health planning, emergency medical care, emergency preparedness, and death investigation.	Local health departments are key prevention partners and serve a vital role in the advancement of population health initiatives. Given the well-defined population health challenges in the region, the PPS sought input from local health departments to develop evidence-based prevention initiatives and ensure that prevention-initiatives were incorporated in the



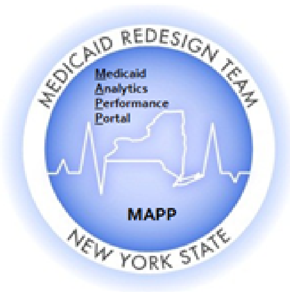
New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP PPS Organizational Application

Samaritan Medical Center (PPS ID:45)

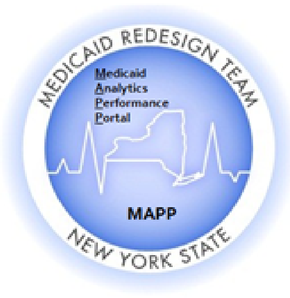
[Samaritan Medical Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			design of an Integrated Delivery System.
10	Jefferson Rehabilitation Center (Chapter of NYSARC)	An independent, not-for-profit corporation providing programs and services to more than 1000 children and adults in Jefferson County who are developmentally disabled. JRC provides a wide range of services that are designed to enhance the quality of life and maximize the potential of persons with disabilities through education, vocational opportunities, training, residential services, inclusion, and advocacy in a community-based setting. A dedicated staff of medical, educational and therapeutic professionals, and specially trained direct care personnel provide the necessary support and training to the individuals they serve.	The development of an equitable integrated delivery system requires input from a wide range of providers and agencies involved in the spectrum of care. JRS's noted history with the developmentally disabled population provides valuable insight for the PPS.
11	Credo Community Center	A not-for-profit organization providing services and treatment to individuals, groups, families, adults, adolescents and children, whose lives have been negatively impacted by substance abuse. Offers outpatient services, residential services and a licensed mental health clinic.	Mental illness is the single highest cause of preventable inpatient admission and emergency department visit in our region. The suicide rate for the region is nearly twice the state rate and Medicaid beneficiaries surveyed indicated that mental illness was the number one health concern in their community. To effectively address the behavioral health needs of our population the PPS relied on their expertise, experience and advocacy.
12	North Country Family Health Center	A Federally Qualified Health Center providing health care to the underserved and uninsured. The Center offers pediatric, adult medical and dental care in Jefferson and Lewis Counties. North Country Family Health Center also operated several WIC Clinics and School-Based Health Centers throughout Jefferson and Lewis Counties.	FQHC's regularly interface with the target population and have the insight, reach and experience required to assist the PPS to engage and activate low-income residents within the region. They are critical components of the care delivery system, also offering prevention services and playing a vital role in the coordination of care.
13	Service Employees International Union 1999 (SEIU)	An affiliate of the largest labor union in North America, SEIU serves healthcare workers employed in homecare agencies, hospitals, nursing homes, pharmacies, clinics and other healthcare settings.	The redesign of the care delivery system hinges on workforce modifications – hiring, retraining, and redeployment. To effectively engage the healthcare workforce and ensure smooth transitions during system reconfiguration, labor unions serving healthcare workers need to be involved in the development of PPS strategies.
14	New York State Nurses Association (NYSNA)	The New York State Nurses Association is a union of 37,000 frontline nurses. The Association focuses on establishing safe staffing practices, preventing hospital closures, defending professional wages and benefits, and developing an equitable healthcare system.	The redesign of the care delivery system hinges on workforce modifications – hiring, retraining, and redeployment. To effectively engage the healthcare workforce and ensure smooth transitions during system reconfiguration, labor unions serving healthcare workers need to be involved in the development of PPS



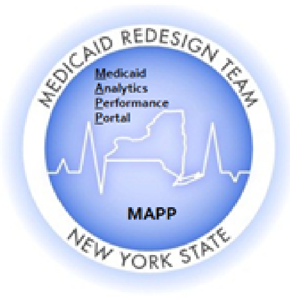
[Samaritan Medical Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			strategies.
15	CNY Health Home Network	Provides comprehensive care coordination and management services for people with complex combinations of chronic conditions. CNY Health Home Network provides a dedicated care manager to help eligible Medicaid members navigate the complex medical, behavioral and social service systems. Services include case management, care coordination, comprehensive transitional care, patient and family support, and social support referrals.	There is a substantial need to support smooth care transitions from inpatient to outpatient settings for at risk patients with chronic disease and mental illness within the PPS. CNY HHN therefore serves as a vital provider in the care continuum and an experienced partner in system redesign.
16	Samaritan Medical Center	A 294-bed not-for-profit community medical center, offering a full spectrum of inpatient and outpatient healthcare services. The hospital services range from primary and emergency care to highly specialized medical and surgical services, such as cancer treatment, neonatal intensive care, behavioral health and addiction services, and imaging services. In addition to the inpatient and outpatient services available at the main hospital and numerous community clinics and satellite testing centers, Samaritan serves the community's long-term care needs at Samaritan Keep Home, a 272-bed long-term care facility, and a 288-bed long-term care and assisted living facility, Samaritan Summit Village.	SMC is the lead PPS facility and has been meaningfully engaged in the development of a patient-centered delivery system for several years. Much like the other hospitals involved, SMC is a critical partner in the development of an integrated care delivery system and a medical village with strong emphasis on care coordination. Several facilities also provide vital primary care outpatient services and wellness initiatives that will help the PPS to develop a patient-centered system that truly serves the needs of the target population, improves prevention efforts and reduces avoidable hospital use.
17	Clifton Fine Hospital	A rural, 20-bed Critical Access Hospital providing a host of quality services to approximately 5,000 year-round residents and approximately 4,000 seasonal visitors in southern St. Lawrence County. The hospital also has 9 Acute Care beds, 11 Long Term Care beds, and provides Swing Bed services. The Hospital provides 24-hour Emergency Room, physical therapy, radiology, and pharmacy services.	Hospitals are critical partners in the development of an integrated care delivery system and a medical village with strong emphasis on care coordination. Several facilities also provide vital primary care outpatient services and wellness initiatives that will help the PPS to develop a patient-centered system that truly serves the needs of the target population, improves prevention efforts and reduces avoidable hospital use.
18	North Country Prenatal/Perinatal Network	A not-for-profit agency serving the maternal and family health needs to Jefferson, Lewis and St. Lawrence Counties. The agency works to identify health care needs and improve access to care through community collaboration, education and referral. Services include health insurance assistance, community health advocates, Supplemental Nutrition Assistance, maternal services, infant services, and adolescent health services.	The Council has been successfully engaging with the Medicaid and uninsured population for many years to address prenatal health and patient navigators for facilitated enrollment. This direct hand-off to navigators who are prominently placed at hot spots, partnered CBOs, emergency departments, or community events allows them to facilitate education regarding health insurance coverage, age appropriate primary and preventive health care services and resources. Their successful work is reflected in noteworthy, positive health indicators



[Samaritan Medical Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			in most maternal health areas.
19	United Helpers	Provides homes and services for thousands of North Country seniors, developmentally disabled and mentally ill people and their families. United Helpers offers a variety of services ranging from independent retirement communities to complete long-term care.	The development of an equitable integrated delivery system requires input from a wide range of providers and agencies involved in the spectrum of care. JRS's noted history with the developmentally disabled population provides valuable insight for the PPS.
20	River Hospital	A general medical and surgical non-profit hospital with 11 beds. Provides inpatient care, emergency services and outpatient services for routine and diagnostic testing. River Family Health Center offers a variety of primary care services, on premise, for the entire family. The Ambulatory Surgical Unit offers same day surgery on an outpatient basis for a number of specialties. River Hospital Convenient Care offers same day non-emergency appointments.	Hospitals are critical partners in the development of an integrated care delivery system and a medical village with strong emphasis on care coordination. Several facilities also provide vital primary care outpatient services and wellness initiatives that will help the PPS to develop a patient-centered system that truly serves the needs of the target population, improves prevention efforts and reduces avoidable hospital use.
21	Civil Service Employees Association (CSEA)	A labor union representing employees in state and local government, school districts, child care, and the private sector. The CSEA works to protect and improve employment conditions and protect individual rights.	The successful redesign of the care delivery system hinges on workforce modifications – hiring, retraining, and redeployment. To effectively engage the healthcare workforce and ensure smooth transitions during system reconfiguration, labor unions serving healthcare workers need to be involved in the development of PPS strategies.
22	Massena Memorial Hospital	A municipal general medical and surgical hospital with 50 beds. Services include a surgical unit, maternity center, pediatric care, cardiac intensive care, rehabilitation and wellness programs, and several outreach programs and clinics engaging veterans, women and children. Weekly clinics are held with visiting specialists in pulmonology, oncology and nephrology.	Hospitals are critical partners in the development of an integrated care delivery system and a medical village with strong emphasis on care coordination. Several facilities also provide vital primary care outpatient services and wellness initiatives that will help the PPS to develop a patient-centered system that truly serves the needs of the target population, improves prevention efforts and reduces avoidable hospital use.
23	Can Am Youth Services (dba Rose Hill)	Provides Residential Rehabilitation Services For Youths, specializing in adolescent drug and alcohol addiction. The youth chemical dependency center provides inpatient care for adolescents from St. Lawrence County, Jefferson County, and many other regions in New York State and Canada.	Mental illness is the single highest cause of preventable inpatient admission and emergency department visit in our region. The suicide rate for the region is nearly twice the state rate and Medicaid beneficiaries surveyed indicated that mental illness was the number one health concern in their community. To effectively address the behavioral health needs of our population the PPS relied on their expertise and



New York State Department Of Health
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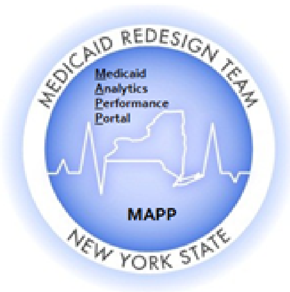
DSRIP PPS Organizational Application

Samaritan Medical Center (PPS ID:45)

[Samaritan Medical Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			experience.
24	Family Counseling Services of NNY	Family Counseling Service is a private, not-for-profit agency which provides a broad spectrum of high quality, affordable counseling, consultative and educational services for individuals and families.	Mental illness is the single highest cause of preventable inpatient admission and emergency department visit in our region. The suicide rate for the region is nearly twice the state rate and Medicaid beneficiaries surveyed indicated that mental illness was the number one health concern in their community. To effectively address the behavioral health needs of our population the PPS relied on their expertise and experience.
25	Jefferson County Community Services	County department responsible for the administrative oversight and planning of services and interventions in Jefferson County for individuals with chemical dependency, mental illness and developmental disabilities.	Mental illness is the single highest cause of preventable inpatient admission and emergency department visit in our region. Substance abuse rates are also high and when surveyed, Medicaid beneficiaries indicated that mental illness was the number one health concern in their community. To effectively address the behavioral health needs of our population the PPS relied on the department of Community Services for their expertise and experience.
26	Lewis County Community Services	County department responsible for the administrative oversight and planning of services and interventions in Lewis County for individuals with chemical dependency, mental illness and developmental disabilities.	Mental illness is the single highest cause of preventable inpatient admission and emergency department visit in our region. Substance abuse rates are also high and when surveyed, Medicaid beneficiaries indicated that mental illness was the number one health concern in their community. To effectively address the behavioral health needs of our population the PPS relied on the department of Community Services for their expertise and experience.
27	St. Lawrence County Chemical Dependence Services	County department offering services to families and individuals with alcohol abuse and/or substance abuse problems. Also provides outpatient counseling and referrals to inpatient treatment for individuals, groups and families, regardless of ability to pay.	Substance abuse is a leading indicator of poor health outcomes and avoidable hospital use within the region. Agencies that successfully engage and treat individuals with substance abuse issues are essential to the PPS strategy to reduce preventable admissions and ER utilization.
28	St. Lawrence Psychiatric Center (NYS OMH)	Offers residential and outpatient services to individuals in Jefferson, Lewis and St. Lawrence counties. Residential programs include adult services, sex offender treatment and children/youth services. Outpatient clinics and residential programs offer assessment, treatment, therapy and case	Mental illness is the single highest cause of preventable inpatient admission and emergency department visit in our region. The suicide rate for the region is nearly twice the state rate and Medicaid



DSRIP PPS Organizational Application

Samaritan Medical Center (PPS ID:45)

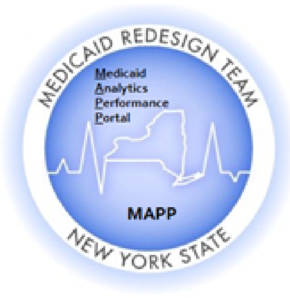
[Samaritan Medical Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		management services.	beneficiaries surveyed indicated that mental illness was the number one health concern in their community. To effectively address the behavioral health needs of our population the PPS relied on their expertise and experience.
29	Catholic Charities – Diocese of Ogdensburg	Charitable faith-based organization responding to the needs of the most vulnerable members of the community. Works to empower individuals and families through direct aid, counseling, community programs, outreach and advocacy.	Population-wide projects and initiatives targeting the low-income population require the input, expertise and advocacy of agencies that have a proven track record of empowering the underserved.
30	Community Action Planning Council of Jefferson County	One of 50 Community Action Agencies in NYS working to assist, support and empower low-income households with specialized programs and services. Programs include Head Start, Universal Pre-K (in partnership with two local school districts), the Jefferson-Lewis Childcare Project, housing and energy assistance, and a Family Center.	Population-wide projects and initiatives targeting the low-income population require the input, expertise and advocacy of agencies that have a proven track record of empowering the underserved.
31	Watertown Urban Mission	Charitable faith-based organization with more than 50 member churches serving residents of the city of Watertown and throughout Jefferson County. The Mission helps residents through programs such as a food pantry, emergency assistance, Christian fellowship, alternative to incarceration for individuals with addictions, thrift store and homeless services.	Population-wide projects and initiatives targeting the low-income population require the input, expertise and advocacy of agencies that have a proven track record of empowering the underserved.
32	Jefferson County Department of Social Services	County department providing services for the low-income residents of Jefferson County.	Population-wide projects and initiatives targeting the low-income population require the input, expertise and advocacy of agencies that have a proven track record of empowering the underserved.
33	L. Woerner, Inc. (dba HCR)	Certified Home Health Agency offering community health services and specialty programs including nursing, physical, occupational, speech and language therapies, home health aides and personal care aides.	An integrated care delivery system depends upon the involvement of stakeholders across the care continuum. Additionally, given the existing need for improved care coordination.
34	Meadowbrook Terrace Adult Home and Home Care Agency	Licensed Home Care Services Agency serving Jefferson, Lewis and St. Lawrence Counties. Provides home health aides and nursing care.	An integrated care delivery system depends upon the involvement of stakeholders across the care continuum. Additionally, given the existing need for improved care coordination.
35	Northern Lights Health Care Partnership, Inc.	Certified Home Health Agency serving St. Lawrence County. Provides home health aides, medical social services, medical equipment, nursing care, nutritional support, and occupational, physical and speech therapies.	An integrated care delivery system depends upon the involvement of stakeholders across the care continuum. Additionally, given the existing need for improved care coordination.
36	Hospice and Palliative Care of St. Lawrence Valley	Serving residents of St. Lawrence County through home visits, pain and symptom management, personal care, emotional and spiritual support, patient and care giver education, care coordination and grief support.	An integrated care delivery system depends upon the involvement of stakeholders across the care continuum. Additionally, given the existing need for improved care coordination. HPC of St. Lawrence

Samaritan Medical Center (PPS ID:45)

[Samaritan Medical Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			Valley also has valuable expertise in Patient Activation Measures and will help to inform the PPS strategy regarding activation and engagement of low-income populations.
37	Lewis County Public Health	Local health department working to prepare, educate and protect the residents of Lewis County. Provides the Cancer Services Program of Lewis and Jefferson Counties, a range of prevention services and services for children with special needs.	Local health departments are key prevention partners and serve a vital role in the advancement of population health initiatives. Given the well-defined population health challenges in the region, the PPS sought input from local health departments to develop evidence-based prevention initiatives and ensure that prevention-initiatives were incorporated in the design of an Integrated Delivery System. LCPH also serves as the region's leader in the delivery of the Cancer Services Program which will serve as a core component of the population-wide initiatives.
38	Points North Housing Coalition	Points North Housing Coalition brings together supportive housing providers across the region to ensure housing capacity for the homeless and near homeless.	Population-wide projects and initiatives targeting the low-income population require the input, expertise and advocacy of agencies that have a proven track record of empowering the underserved.
39	Health Services of Northern NY	Health Services of Northern New York, Inc. is a Certified Home Healthcare Agency (CHHA) servicing Potsdam, Canton, Ogdensburg, Massena, Gouverneur, and surrounding areas of St. Lawrence County.	There is a substantial need to support smooth care transitions from inpatient to outpatient settings for at risk patients with chronic disease and mental illness within the PPS. HSNNY therefore serves as a vital provider in the care continuum and an experienced partner in system redesign.
40	Highland Nursing Home	Provides subacute care and rehabilitation therapies to long-term residents. Offers individual and family counseling, wellness planning, social services, dental services, nursing rehab and several therapies.	LTC facilities represent a vital component in the development of an integrated delivery system with optimum care coordination supports.
41	Feed the Soul	A health and nutrition education firm offering a wide range of nutrition services aimed at improving health and maintaining overall wellness. Owned and operated by one of the few Certified Diabetes Educators in the region.	Diabetes can be effectively treated in the outpatient setting. Over 40% of Medicaid beneficiaries indicated diabetes as a concern. Diabetes is the fourth highest driver of inpatient and ED use for the target population. The region performs below state average on the adult diabetes composite and short-term complications of diabetes and adult uncontrolled diabetes are of particular concern. Feed the Soul's experience with the diabetic population has proven insightful and will continue to guide the development and implementation of PPS projects.



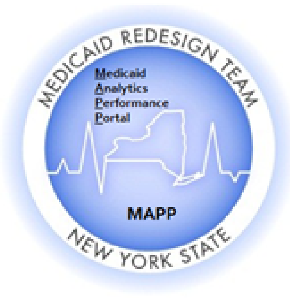
New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP PPS Organizational Application

Samaritan Medical Center (PPS ID:45)

[Samaritan Medical Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
42	Watertown Family YMCA	Faith-based, charitable organization that offers healthy lifestyle programming for all ages while fostering positive individual behaviors. Serves Jefferson County and offers the sole Diabetes Prevention Program (DPP) in the county.	Because Diabetes is significantly impacted by lifestyle and access to nutrition and exercise, it is critical that community based resources be leveraged to impact choices and decisions outside the physician's office walls. Activities like the Diabetes Prevention Program and lifestyle modification programs are critical to patient success and can be life-changing. Resulting in not only fewer avoidable hospitalizations and ED use to achieve DSRIP goals but improved quality of life for both patients and families.
43	St. Lawrence County Health Initiative	Created through a collaboration by Canton-Potsdam Hospital and Claxton-Hepburn Medical Center. Serves the residents of St. Lawrence County and the surrounding region with the Cancer Services Program, Diabetes Prevention Program, Health Insurance Navigators and several wellness programs.	The prevalence of diabetes, colorectal cancer and unhealthy lifestyle behaviors are well defined in the region. This organization provides the PPS with insight, reach, experience and services critical to the success of population-wide interventions.
44	St. Lawrence NYSARC	Serves residents of St. Lawrence County with developmental disabilities. Offers vocational training, arts programs, children and youth services, day habilitation, residential services, family support, service coordination, transportation and wellness interventions.	The development of an equitable integrated delivery system requires input from a wide range of providers and agencies involved in the spectrum of care. St. Lawrence NYSARC's noted history with the developmentally disabled population provides valuable insight for the PPS.
45	Bolton's Pharmacy Inc.	Locally-owned, independent pharmacy serving Jefferson County with services ranging from customized medication solutions, prescription plans for local employers, pharmacy services for nursing homes, durable medical equipment and home health aides.	Pharmacies serve as a critical point of engagement with the target population. They also provide prevention services instrumental to the reduction of avoidable hospital use in the region.
46	KPH Health Services, Inc (Kinney Drugs)	Locally-owned, independent pharmacy serving Jefferson, Lewis and St. Lawrence Counties. Provides pharmacy, health and retail services across the region.	Pharmacies serve as a critical point of engagement with the target population. They also provide prevention services instrumental to the reduction of avoidable hospital use in the region.
47	Howard Meny, MD, PC	Local family practice based in Lewis County and serving a high proportion of Medicaid beneficiaries and low-income residents.	The practice is staffed with providers who have proven instrumental for engagement with the target population and who have provided important insight in the PPS strategy to increase PCMH certification and develop a medical village within the region.
48	Alcohol and Substance Abuse Council	A not-for-profit prevention agency focused on issues related to substance abuse in Jefferson County. Provides prevention and information services for alcohol abuse and alcoholism, underage drinking, substance abuse, problem gambling, smoking cessation, and self-help meetings. Agency is also the	Substance abuse is a leading indicator of poor health outcomes and avoidable hospital use within the region. Agencies that successfully engage and treat individuals with substance abuse issues are essential



Samaritan Medical Center (PPS ID:45)

[Samaritan Medical Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		Jefferson County site for the New York State Drinking Driver Program.	to the PPS strategy to reduce preventable admissions and ER utilization.
49	Seaway Valley Prevention Council	A not-for-profit prevention agency focused on issues related to substance abuse in St. Lawrence County. Provides information and referral, prevention education and training, community awareness, and advocacy related to alcohol and substance abuse prevention.	Substance abuse is a leading indicator of poor health outcomes and avoidable hospital use within the region. Agencies that successfully engage and treat individuals with substance abuse issues are essential to the PPS strategy to reduce preventable admissions and ER utilization.
50	Mental Health Association of Jefferson County	A private not-for-profit organization designed to promote mental health through community education and direct services to mental health consumers and their families. This is done by providing opportunities for mental health consumers to become active participants in their own recovery and independence. The improvement of care and treatment of persons with mental illness with services may include some of the following: advocacy, vocational development, socialization, personal growth, community education and the legislative process.	Mental illness is the single highest cause of preventable inpatient admission and emergency department visit in our region. The suicide rate for the region is nearly twice the state rate and Medicaid beneficiaries surveyed indicated that mental illness was the number one health concern in their community. To effectively address the behavioral health needs of our population the PPS relied on their expertise and experience.
51	Pulmonary Associates of NNY	Medical Group Practice focused on the treatment and prevention of respiratory disorders and diseases.	Throughout the needs assessment it was clear that COPD needed a concentrated prevention strategy. COPD is the third leading cause of hospitalization and emergency room visits for the target population. More than 20% of the region's population smokes and prevention efforts need to be stepped up. Respiratory health providers are critical to the successful design of strategies to address the high rates of COPD within the region.
52	Volunteer Transportation Center, Inc.	The Volunteer Transportation Center runs transport in all three counties and are valued and seen as both capable and caring. These two agencies are important, as lack of housing and transportation are social disparities often correlated with poor health outcomes.	Population-wide projects and initiatives targeting the low-income population require the input, expertise and advocacy of agencies that have a proven track record of empowering the underserved.
53	Office for the Aging (Jefferson, Lewis)	Formed through the efforts of the Community Action Planning Council, Catholic Charities of the Dioceses of Ogdensburg and other area churches. Serves citizens who are 60 years of age and older with a variety of programs – Diabetes Prevention Program (in partnership with the Watertown Y), legal services, home energy assistance, insurance counseling, in-home services, and nutrition services.	Population-wide projects and initiatives targeting the low-income population require the input, expertise and advocacy of agencies that have a proven track record of empowering the underserved. Office for the Aging.
54	St. Lawrence County Public Health	Local health department serving St. Lawrence County through a wide variety of health services and programs designed to improve both individual and community health and well-being.	Local health departments are key prevention partners and serve a vital role in the advancement of population health initiatives. Given the well-defined population health challenges in the region, the PPS sought input

[Samaritan Medical Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			from local health departments to develop evidence-based prevention initiatives and ensure that prevention-initiatives were incorporated in the design of an Integrated Delivery System.

Section 3.8 - Summary of CNA Findings:

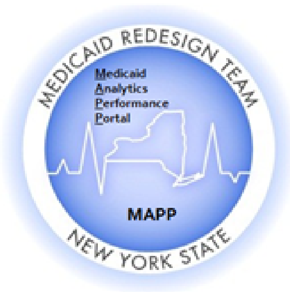
Description:
In the chart below, please complete the summary of community needs identified, summarizing at a high level the unique needs of the community. Each need will be designated with a unique community need identification number, which will be used when defining the needs served by DSRIP projects.

***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.

[Samaritan Medical Center] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
1	Need for integrated delivery system across continuum of care	Health care is currently provided in separate silos with limited ability to share records or care plans. Patients with chronic and complex conditions often have multiple and contradictory care plans with little to no communication between providers or settings. There are no agreed upon protocols for care transitions and little care management across the continuum. The Health Home has little access to engage patients. There is primary care workforce shortage that requires a focused cross-system effort to increase primary care capacity. Community based organizations have little to no interaction with inpatient settings. Patients need facilitated smooth transitions and communication across all care setting.	Primary data collection: surveys, focus groups, key informant interviews Potentially Avoidable Emergency Room Visits Potentially Avoidable Admissions PQI – Composite of All Measures Medicaid Chronic Conditions, Inpatient Admissions, Emergency Room Visits NYS DOH Office of Quality and Patient Safety
2	Need for Patient Centered Medical Home and Advanced Primary Care	Patient Centered Medical Home Certification 2014, advanced primary care, requires that primary care be team oriented, meet quality standards, be meaningfully utilizing health information technology to coordinate care and improve quality of care and be adhering to best-practices for prevention screenings and follow-up. In addition specific patient engagement activities are required. The combination of requirements for PCMH will ensure that prevention and best practices will be	Primary data collection:target population surveys Potentially Avoidable Emergency Room Visits Potentially Avoidable Admissions PQI – Composite of All Measures



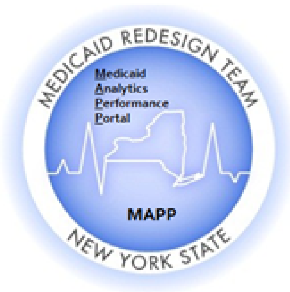
New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP PPS Organizational Application

Samaritan Medical Center (PPS ID:45)

[Samaritan Medical Center] Summary of CNA Findings

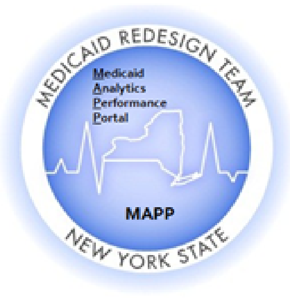
Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		standardized and universally applied resulting in fewer PPVs and PPAs.	Medicaid Chronic Conditions, Inpatient Admissions, Emergency Room Visits NYS DOH OQPS DSRIP Population Health Metrics BRFSS, NYSDOH, SPARCS
3	Need for Medical Home using existing infrastructure	With the changing healthcare landscape hospitals across the region understand the need to reconfigure service structure and supporting infrastructure to meet the new care delivery model. This varies by hospital service site and will include, urgent care where none exists, on-site integration of primary care and behavioral health services and care management.	Healthcare resources database Potentially Avoidable Emergency Room Visits Potentially Avoidable Admissions PQI – Composite of All Measures Medicaid Chronic Conditions, Inpatient Admissions, Emergency Room Visits NYS DOH Office of Quality and Patient Safety (OQPS)
4	Need for greater care transition support to prevent readmissions for at-risk populations	There is a substantial need to support smooth care transitions from inpatient to outpatient settings for at risk patients with chronic disease and mental illness within the PPS. Due to the rural geography and transience of many high-risk patients once they leave the "teaching/engaging" moment at the hospital, the Health Home care managers are unable to find them to engage them in outpatient services and active participation in their care plans that would prevent future hospitalizations and ED use. In addition, it is at this point that home situations (housing, food, heat transportation etc.) can be coordinated with community based supports to ensure the patient has the means to actually comply with care plan recommendations. Without this support at the point of transition patients often leave the hospitals with little capability to support their future health or to make or keep follow-up care appointments.	Primary data collection DSRIP Dashboard C1-C6 Medicaid Population Delivery System Utilization Potentially Avoidable Admissions and readmissions PQI – Composite of All Measures Medicaid Chronic Conditions, Inpatient Admissions, Emergency Room Visits NYS DOH OQPS
5	Need for integration of primary care and behavioral health services	Mental illness is the single highest cause of preventable inpatient admission and emergency department visit. In addition, it is clear that there is a disconnect between behavioral health services and primary care services. PCs report being unable to get their referred patients appointments for BH care and BH providers report being unable to get access to primary care for their behavioral health patients. BH health patients have high rates of co-occurring diabetes, cardiac and respiratory diseases. The suicide rate for the region is nearly	Primary data surveys, PPV, PPA Mental Illness & SA Antidepressant Med Management Cardio monitoring, schizophrenia Follow-up for BH hosp. Screening & follow-up depression Adherence to Medication



Samaritan Medical Center (PPS ID:45)

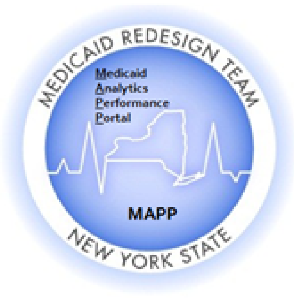
[Samaritan Medical Center] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		twice the state rate and Medicaid beneficiaries surveyed indicated that mental illness was the number one health concern in their community. There is clear and compelling evidence that integrating PC and BH at the primary site of care for the patient is needed.	NCQA & NYSDOH Office of Performance Measurement Suicide rate NYS Prevention Quality Indicators
6	Need for evidence-based strategies for Adult Cardiovascular Disease	Cardiovascular disease can be effectively treated in the outpatient setting. Cardiovascular disease is the second highest driver of inpatient hospitalizations and emergency department use for the target population. The region performs below both NYS and upstate. Primary care implementation of evidence based strategies in the treatment of cardiovascular will result in less ED and inpatient utilization and improved quality of life for beneficiaries.	Primary Data collection Adult circulatory composite (PQI 107, 08) Potentially Avoidable Emergency Room Visits Potentially Avoidable Admissions Medicaid Chronic Conditions, Inpatient Admissions, Emergency Room Visits NYS DOH Office of Quality and Patient Safety (OQPS)
7	Need for evidence-based strategies for Adult Diabetes	Diabetes can be effectively treated in the outpatient setting. Over 40% of Medicaid beneficiaries indicated diabetes as a concern. Diabetes is the fourth highest driver of inpatient and ED use for the target population. The region performs below state average on the adult diabetes composite and short-term complications of diabetes and adult uncontrolled diabetes are of particular concern. Primary care implementation of evidence based strategies in the treatment of diabetes will result in less ED and inpatient utilization and improved quality of life for beneficiaries.	Primary data-survey PPV & PPAs Adult diabetes composite (PQI 1, 3, 16) Short-term complications of diabetes PQI1 Adult uncontrolled diabetes AHRQ Comprehensive Diabetes screening–NCQA Comprehensive Diabetes Care Medicaid Chronic Conditions, Inpatient Admissions, Emergency Room Visits NYS DOH OQPS
8	Need for community strategies for Adult Diabetes	Because Diabetes is significantly impacted by lifestyle and access to nutrition and exercise, it is critical that community based resources be leveraged to impact choices and decisions outside the physician's office walls. Activities like the Diabetes Prevention Program and lifestyle modification programs are critical to patient success and can be life-changing. Resulting in not only fewer avoidable hospitalizations and ED use to achieve DSRIP goals but improved quality of life for both patients and families.	Primary data - survey PPV & PPAs Adult diabetes composite (PQI101, 03, 16) Short-term complications of diabetes PQI1 Adult uncontrolled diabetes AHRQ Comprehensive Diabetes screening and care – NCQA Medicaid Chronic Conditions, Inpatient Admissions, Emergency Room Visits NYS DOH OQPS
9	Need to strengthen mental health and	The need to strengthen mental health and	Primary data surveys,



[Samaritan Medical Center] Summary of CNA Findings

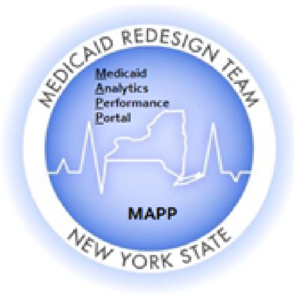
Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
	substance abuse cross-systems infrastructure	substance abuse cross systems infrastructure was identified as a population health priority across multiple focus groups. The regions rates of hospitalizations and emergency department use for mental illness and substance abuse are very high and of deep concern. In addition the binge drinking rate for the region is nearly 25% and the suicide rate is nearly twice the state average. There is clear evidence that there needs to be a cohesive and concerted population health strategy to engage and address mental illness and substance abuse prevention across the continuum.	focus groups, key informant interviews PPV and PPA Mental Illness & SA Medicaid Chronic Conditions, Inpatient Admissions, Emergency Room Visits NYS DOH OQPS Suicide rate Binge Drinking past 30 days NYS Prevention Quality Indicators
10	Need to increase access to chronic disease prevention for respiratory disease & colorectal cancer	Throughout the needs assessment it was clear that respiratory disease and in particular COPD needed a concentrated prevention strategy as did colorectal cancer. COPD is the third leading cause of hospitalization and emergency room visits for the target population. More than 20% of the region's population smokes and prevention efforts need to be stepped up. Colorectal cancer mortality rates exceed NYS rates and Colorectal cancer screening rates are significantly lower than NYS. A concerted effort to advance respiratory disease prevention and incorporate smoking prevention and cessation is needed. A concentrated effort to engage the region in cancer prevention screenings is also need. Both of these activities will impact total health as the region moves from a healthcare system to a system for health.	Primary data surveys, focus groups PPV and PPAs Adult respiratory composite (PQI05,15) Bacterial Pneumonia PQI Medicaid Chronic, Inpatient Admissions, ER Visits NYS DOH OQPS Respiratory disease & Colorectal cancer mortality Smoking rate Colorectal screening rate NYS Prevention Quality Indicators
11	Need for patient activation to engage uninsured and Medicaid LU/NU in community based care.	Currently often the only contact that the uninsured and Medicaid NU/LU have with the healthcare system is through the emergency department or an acute care hospitalization. Engaging this population in the healthcare system can prevent future ED and inpatient utilization and prevent future onset of chronic disease.	Primary data collection: target population surveys Potentially Avoidable ER Visits Potentially Avoidable Admissions PQI – Composite of All Measures Medicaid Chronic Conditions, Inpatient Admissions, Emergency Room Visits NYS DOH OQPS DSRIP Population Health Metrics BRFSS, NYSDOH, SPARCS



File Upload: (PDF or Microsoft Office only)

Please attach the CNA report completed by the PPS during the DSRIP design grant phase of the project.

File Name	Upload Date	Description
45_SEC038_NCI CNA 2014 Upload.pdf	12/18/2014 09:49:56 AM	NCI CNA 2014 Upload



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: **Samaritan_Section4_Text_DSRIP Project Plan Application _ Section 4.Part I(text).12.10.14.docx**

Description of File

NCI Samaritan DSRIP Project Plan Application

File Uploaded By: hsanchez

File Uploaded On: 12/22/2014 03:10 PM

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

Currently Uploaded File: **Samaritan_Section4_ScopeAndScale_FINAL_DSRIP Project Plan Application _Scale Speed UPDATED _ 20141205.xlsx**

Description of File

NCI Samaritan Scope and Scale

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SECTION 5 – PPS WORKFORCE STRATEGY:

Section 5.0 – PPS Workforce Strategy:

Description:

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

The following subsections are included in this section:

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

Scoring Process:

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

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

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

Description:

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

***Strategy 1:**

In the response, please include

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

The NCI region is a designated Health Professional Shortage Area (HPSA) for both primary and behavioral health, thus patient's experience barriers to accessing care, the lack of an assigned provider, or the inability to receive a timely appointment. To address gaps and fulfill project requirements, strengthening the workforce supply through innovation in role and task allocation will be essential.

The NCI will prioritize retraining to expand efficiency and productivity, promote care coordination, and enhance teamwork. To achieve deliverables of project 2bi (IDS) and 2biv (care transitions), the CNA Chart of Needs indicates that "there is a need to support smooth care transitions from inpatient to outpatient settings for at risk patients with chronic disease and mental illness within the PPS" and "there are

no agreed upon protocols for care transitions and little care management across the continuum." Training related to standardized protocols, record transfer, health literacy, cultural competency and patient education will be required. NCI's clinical governance will approve and publish protocols to manage overall population health, improve work flow, and perform as an integrated team. Through retraining, we will increase the ability for professionals to practice at the top of their license. Participating PCPs will utilize their EHRs and the interoperability provided by the HIE to enable professionals to effectively manage patients across the continuum. To support the need for Patient Centered Medical Home (PCMH) and Advanced Primary Care (APC) as indicated in the CNA, all staff will be trained, applicable to their role, on PCMH or APC models, thus "meaningfully utilizing health information technology to coordinate care, improve quality of care and adhere to best practices for prevention screenings and follow-up." These efforts, along with others, will require written training materials, time and resources, all of which the NCI is committed to providing.

Very little, if any redeployment or workforce reductions will take place, as the system structure is lean, as noted by our HPSA designation. Any reductions created in years 3-5 will be absorbed through employee attrition. However, according to the CNA, "there is a primary care (PC) workforce shortage that requires a focused cross-system effort to increase PC capacity" and there is a negative ratio (per 100,000) of PC physicians (region 74, NYS 120), dentists (region 44, NYS 78) and psychiatrists (region 17, NYS 36) in the region. This will require improved financial incentives such as sign on bonuses or loan forgiveness, efforts to expand regional Graduate Medical Education, and alignment with statewide collaborative programs to recruit, train and hire providers.

Existing categories that will be impacted include community health workers (CHWs), care coordinator/transition managers, certified diabetes educators (CDEs), pharmacists, physicians, physician assistants, nurse practitioners, psychiatrists, dentists, behavioral health (BH) and health information technology (HIT) workers, and nurses.

CHWs, care coordinators/transition managers and others, will develop and implement PPS wide protocols and processes for engagement of community support services (i.e. CDEs and dentists) and focused referrals of health home (HH) services, home care agencies, palliative care, and primary care practices. Pharmacists will be engaged as a member of the team assisting with medication reconciliation. With the assistance of HIT staff, systematic record transitions and patient engagement activities (meeting PCMH and APC requirements) will be developed and implemented by primary and BH care providers. Cross functional teams will be established, ensuring patients receive appropriate, integrated care including medical and BH, post-acute care, LTC, and public health services.

***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.

It is anticipated that there will be little negative impact to the workforce, as the NCI strategy will aim to leverage existing resources and enhance active interventions to prevent work overloads and reduce stress related to attrition. Retraining and retaining professionals through strategic, effective methods such as human resource planning, incentivizing providers, providing education, training and career advancement, as well as workforce protections will improve the practice environment in the Tug Hill Seaway region. The NCI will also seek to align and intersect with existing State program efforts such as Doctors across New York, Physician Loan Repayment, and Healthcare Workforce Retraining Initiatives to recruit, retrain and retain professionals in our communities. The NCI will engage frontline workers, regional stakeholders and labor/worker representatives throughout the planning, development and implementation of strategies, ensuring collaboration and transparency. Finally, the NCI will continue to collaborate with proven workforce strategy vendors such as the Iroquois Health Alliance, Northern Area Health Education Center, and the Fort Drum Regional Health Planning Organization to analyze the integrated delivery system, identify workforce gaps, and leverage community resources, thus equipping our healthcare professionals with the skills and training to operate in a preventive, community-based system.

The entire NCI region has been federally designated as a Medicaid Health Professional Shortage Area (HPSA). According to data from the 2013 Center for Health Workforce Studies Guide, there are significantly fewer active primary care providers, per 100,000 population, practicing in the region (74) than statewide (120). There are also fewer active physician specialists and allied health professionals within the region than statewide. For example, there are 104 (per 100,000) physician specialists regionally as compared to 228 statewide, fewer dentists (region 44, NYS 78) and less than half the psychiatrists capacity (region 17, NYS 36). Additionally, there are 17 dieticians/nutritionists regionally compared to 23 statewide. All The outlined challenges are exacerbated by the population demographics for the region. Compared with statewide averages, the NCI region's population is older, has lower income, has a disproportionate burden

of chronic diseases, mental illness and substance abuse, and has higher rates of uninsured children.

NCI's ongoing efforts to provide coordinated, patient centered care across providers will be challenged greatest by the shortage of primary and behavioral health care. As a result, patients often experience barriers to accessing care, lack an assigned provider, or lack the ability to receive appointments in a timely manner. These challenges are being addressed through the PPS plan to grow primary care capacity, to back up providers so that each clinician can operate at the top of their license with maximum efficiency, through the integration of primary care and behavioral health which expands access points of care to meet the patient where they are, and through the utilization of telehealth to expand options for access to care.

***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	50%
New Hire	1%

Section 5.2 – WORKPLACE RESTRUCTURING - RETRAINING EXISTING STAFF :

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

Description:

Please outline the expected retraining to the workforce.

***Retraining 1:**

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

The NCI workforce strategy will retrain health care workers for patient centric models of care as the healthcare market evolves in response to patient needs, advanced technology, and increased outpatient care delivery. With an increased demand for healthcare services from newly insured patients, a shortage of primary care and other health professionals, a lack of integration of primary and behavioral health care, limited care management and regulatory/scope of practice issues, our strategy will prioritize retraining. This strategy will aim to ensure efficiency, promote care coordination, enhance collaboration and leverage technology infrastructure.

Redesign Processes: The development and implementation of standardized protocols, improvement in workflow processes, utilization of EHRs and the interoperable HIE to enable effective care management across the care continuum, as well as training related to identification and treatment for patients at highest risk for readmissions (i.e. the PHQ-9 and SBIRT protocols, workflow and processes, hypertension visit schedule, patient activation measure, etc.) will be the emphasis of NCI's strategy. As the PPS strengthens its effort to engage patients in their care all frontline workers will receive cultural competency and health literacy training.

New Roles: NCI will evaluate new or expanded roles or new delivery alternatives allowing providers to practice at the top of their license, especially within the primary care setting. We will seek to provide scholarships and loan repayments to students, residents and providers in exchange for service obligation, specifically targeting service for the Medicaid population.

Existing Partnerships & Certifications: NCI will leverage existing partnerships with the Fort Drum Regional Health Planning Organization (FDRHPO) and the Northern Area Health Education Center (NAHEC) to increase awareness of health education pathways, job placement and career exploration resources, and clinical rotations. The NCI will also work with Jefferson Community College, the State University of New York and the Iroquois Health Alliance (IHA) to conduct training-needs assessments and select training or academic partners to create and deliver training modules or curriculum. IHA has successfully demonstrated the ability to identify eligible candidates for training

programs, organize appropriate trainings, and assist with retention and employment for trained individuals in the health care sector. The IHA also has an existing partnership with HealthStream to deliver online training PPS employees, specifically as it relates to engaging and training frontline workers to improve outcomes due to cultural competency challenges, population health, transitional care, process improvement and care coordination. Where curriculum gaps exist, we will work together to identify, and when feasible, create new courses. Given their established infrastructure, collaborative relationships with government agencies and multiple stakeholders, the FDRHPO, NAHEC and IHA are uniquely prepared to assist NCI.

Retraining will be involuntary and integrated into the current human resource training schedule. If necessary, we will capitalize on extensive human resource planning and workforce protections to improve the practice environment. Also, to facilitate buy-in and to minimize any negative impact to the workforce, the NCI will actively engage frontline workers and labor representatives when and where applicable to ensure that any retraining requirements meet the needs of the PPS and workforce. NCI will also incentivize primary care providers to train and serve the NCI region. Overall, transparency and active engagement in the planning and development of training will ensure successful implementation.

***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.

It is not anticipated that there will be an immediate impact on current wages and benefits of existing employees; however, when and if there was an impact, the specific human resource (HR) department will perform any necessary benchmarking of salary bands/overall benefits. Additionally, before an individual is offered or selected to retrain, the HR departments will prepare packets with a detailed comparison of current and target positions, including salary, benefits, role, responsibilities, and training. The majority of the NCI training approach will include coordinated care that lends to more efficient workflow processes ensuring patients receive appropriate, integrated care and community support.

***Retraining 3:**

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

There is little to no redeployment assignments or anticipated ramifications to existing NCI employees, and it is anticipated that any reductions in future years will be through employee attrition. If at any time redeployment become anticipated than the human resource departments will work with their labor representatives to develop a mutually agreed upon strategy for redeployment.

NCI facilities operate with limited human and financial resources while delivering high quality care. It is also worth noting that recent strategic planning has decreased staffing levels and reduced the number of inpatient beds, as three NCI hospitals are designated critical access.

***Retraining 4:**

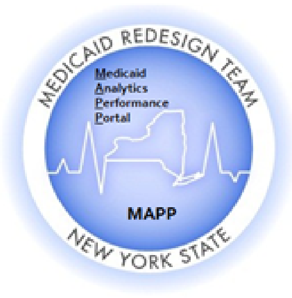
Describe the role of labor representatives, where applicable – intra or inter-entity – in this retraining plan.

The NCI Project Advisory Committee is advising the PPS on project plans and includes representation from PPS partners as well as workers and relevant unions to include the Civil Service Employees Association (CSEA), the New York State Nurses Association (NYSNA) and the Service Employees International Union (SEIU). As members of the PAC, these union representatives offer recommendations and feedback on PPS initiatives and are involved in various facets of the developing project plans (i.e. training initiatives that are designed to meet the needs of the transforming system) to include the integrated workforce strategy. They have been consulted and will continue to remain engaged in the implementation and oversight of the project plans.

***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	100%
Partial Placement	0%



Section 5.3 - WORKPLACE RESTRUCTURING - REDEPLOYMENT OF EXISTING STAFF :

Description:
Please outline expected workforce redeployments.

***Redeployment 1:**
Describe the process by which the identified employees and job functions will be redeployed.

Minimal to no reduction in staffing or redeployment will be necessary to accomplish the project initiatives of the NCI. The current system structure is lean, as noted by our behavioral health and primary care Health Professional Shortage Area (HPSA) designation which causes barriers to accessing care, the lack of an assigned provider, or the inability to receive a timely appointment.

While the NCI PPS is under growing pressure to find the most cost-effective and efficient workforce models to serve the growing number of individuals seeking healthcare services, based on current staffing levels it is not expected that existing employees will be required to redeploy to other job titles unless they desire to move.

The focus will be on training in improved protocols, team-based care, health literacy, the use of health information technology and patient centered care. The NCI PPS will continuously track the supply and demand for workers in emerging titles to inform the workforce strategy with input from all stakeholder groups. Strengthening the workforce supply through innovation in role and task allocation will be an essential component of the NCI workforce strategy, which will prioritize training/retraining efforts.

***Redeployment 2:**
Describe the process and potential impact of this redeployment approach, particularly in regards to any identified impact to existing employees' current wages and benefits.

The NCI's integrated workforce strategy does not include redeployment, but rather training/retraining. This training/retraining approach will include coordinated and integrated care that lends to more productive and efficient workflow processes. These new and/or improved processes, policies and procedures will ensure patients receive appropriate health care and community support including medical and behavioral health, post-acute care, long-term care and public health service. Due to the current workforce shortages and recent strategic staffing reductions and restructuring, the NCI workforce strategy will not impact the current wages and benefits of existing employees.

***Redeployment 3:**
Please indicate whether the redeployment will be voluntary. Articulate the ramifications to existing employees who refuse their redeployment assignment.

The NCI aims to ensure that existing employees within the PPS have the opportunity to contribute the delivery system. It is not anticipated that staff will be asked to work in a different organization, department or location, as the current system structure is lean, as noted by our Health Professional Shortage Area (HPSA) designation. Rather than redeploy or reduce the workforce, our strategy seeks to train staff to incorporate new care models and to increase community healthcare professional supply in shortage occupations and emerging titles. NCI is committed to providing written training materials, and necessary resources to support healthcare transformation, service integration, and provider communication/coordination, thus minimizing negative impacts to the existing workforce.

***Redeployment 4:**
Describe the role of labor representatives, where applicable – intra or inter-entity – in this redeployment plan.

The NCI Project Advisory Committee is advising the PPS on project plans and includes invited representation from PPS partners as well as workers and relevant unions to include the Civil Service Employees Association (CSEA), the New York State Nurses Association (NYSNA) and the Service Employees International Union (SEIU). As members of the PAC, union representatives offer recommendations and feedback on PPS initiatives and are involved in various facets of the developing project plans to include the integrated workforce strategy. Labor representatives have been valuable to the process and will continue to be engaged in the implementation and oversight of the project plans.

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.

Through the creation of an integrated delivery system focused on evidence-based medicine/population health management, the NCI will re-balance the health care delivery system in ways that are consistent with the health care needs of the community served by the IDS. We will ensure care coordination across all settings, support EHR linkages by participating in the local RHIO, expand access to primary care and increase primary care capacity, evolve provider compensation and performance management systems, and develop process improvement capabilities. Additionally, where appropriate, we will seek to utilize community health workers, peers and culturally competent community-based organizations to assist with patient outreach and navigation.

To engage PPS partners, including Medicaid members, in the design and implementation of this system transformation, the NCI will need to establish cross functional teams that span the delivery system including hospitals, long-term care, the health home, hospice and community based organizations that integrate existing social/community support services, behavioral health agencies, chemical dependency programs, and remote monitoring services. Some of the workforce categories needed to fulfill these project requirements already exist, yet others will be created as a result of the implementation of the DSRIP program and NCI projects.

Recognizing that coordinated and smooth transitions of care across systems is a goal of both DSRIP and the NCI, NCI will look to hire the following workers to assist with this process: Community Health Workers/Patient Navigators, Care Coordinators/Care Managers and Care Transition Managers. The roles of these titles may differ by care model, and activities associated with them may vary based on the needs of the patient population being served, the services provided, and the skills and competencies of the individuals in these titles. For example, care coordinators may be registered nurses, licensed practical nurses, bachelor's prepared social workers, or master's prepared social workers. In addition, as we aim to expand and increase access to primary care and behavioral health, the NCI will need to incentivize and hire healthcare providers in shortage categories, with a focus on primary care physicians, nurse practitioners, physician assistants, psychiatrists and dentists. This remains a critical need, as the NCI region has been designated a Medicaid-eligible primary care, dental care, and mental healthcare HPSA and the CNA clearly showed that access to care is impacting the health outcomes and service utilization of the Medicaid and uninsured population to be served by the PPS. Each of these professionals will play an integral role in the successful implementation of protocols and processes ensuring patients receive high quality appropriate health care and community support when and where they need it.

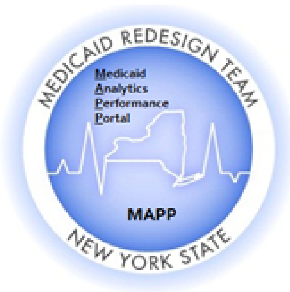
In the table below, please itemize the anticipated new jobs that will be created and approximate numbers of new hires per category.

Position	Approximate Number of New Hires
Administrative	4
Physician	8
Mental Health Providers Case Managers	4
IT Staff	6
Nurse Practitioners	2
Other	12

☑ 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	300,000	400,000	300,000	100,000	100,000	1,200,000
Redeployment	0	0	0	0	0	0
Recruiting	1,000,000	2,000,000	1,000,000	500,000	500,000	5,000,000
Other	200,000	200,000	100,000	200,000	100,000	800,000



Section 5.6 – State Program Collaboration Efforts:

***Collaboration 1:**

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

NCI recognizes that there are a large and ever-evolving number of programs that both NYS and the Federal Government provide to help with training, education, retraining, etc. for health care workers at many levels. To take advantage of these programs, NCI has a workgroup to identify government program opportunities and to lead the response, application, and submission for funds focused specifically on NYS programs.

We have identified the need to retrain all PPS clinical staff in cultural competency and health literacy and the need to provide training and education for at least 14 care coordination and care managers to be recruited, and recruit 36 professionals including the care managers/coordinators. The challenge to affect the workforce landscape requires significant collaboration with the State Workforce Investment Board (SWIB), SUNY, Area Health Education Centers (AHECs), and others. NCI will collaborate with its workforce strategy partners, the Iroquois Healthcare Association (IHA) to assist in delivering/executing our workforce strategy and to augment recruitment, retention, and training across multiple organizations when needed. IHA will collaborate with the Northern Area Health Education Center (NAHEC) to ensure coordination of NCI program initiatives. IHA's has experience collaborating with national and regional partners on training projects impacting more than 9,000 health care workers include HWRI Health Workforce Retraining Initiatives (DOH), TANF Health Worker Retraining Initiatives (DOH), Emerging and Transitional Worker Training Initiative (DOL), and Strategies to Assist Workers Impacted by the Berger Commission (DOL).

Recruitment of physicians and other health professionals is critical to our success. While the Doctors Across New York (DANY) is not currently accepting applications, DANY, and the Primary Care Service Corps are being monitored for new rounds of funding.

Section 5.7 - Stakeholder & Worker Engagement:

Description:

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

***Engagement 1:**

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

The NCI has project committees and work groups which are comprised of frontline workers and project initiative subject matter experts who are informing the PPS strategy by identifying workforce gaps as they relate to project deliverables. This gathered information was then shared with the workforce committee consisting of human resource representatives, labor/union/worker representatives, and proven workforce vendors to include the Fort Drum Regional Health Planning Organization (FDRHPO), the Northern Area Health Education Center (NAHEC) and the Iroquois Health Alliance (IHA). Additionally, for the workforce meeting with KPMG, project leads (i.e. Discharge Planners, RNs, Physicians, Behavioral Health professionals (LMSW, LMHC), PCMH and HIT experts, etc.) from each committee/workgroup and labor representatives were invited to inform strategies related to workflow and training issues around the chosen NCI projects.

***Engagement 2:**

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

The NCI Project Advisory Committee is advising the PPS on project plans and includes invited representation from PPS partners as well as workers and relevant unions to include the Civil Service Employees Association (CSEA), the New York State Nurses Association (NYSNA) and the Service Employees International Union (SEIU). As members of the PAC, these union representatives offer recommendations and feedback on PPS initiatives and are involved in various facets of the developing project plans to include the integrated workforce strategy. Labor representatives have been valuable to the process and will continue to be engaged in the implementation and oversight of the project plans.

***Engagement 3:**

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

Project committees, including frontline workers, are informing the strategy by identifying workforce gaps related to project deliverables. Along with the CNA, this information will be incorporated into plans and implementation. Frontline workers will continue to inform the process through e-mail and committee meetings.

Additionally, the NCI has a Communications Committee consisting of marketing staff from participating NCI hospitals, the Health Home, an FQHC and a workforce vendor. While monitoring community engagement, this group has analyzed and identified key stakeholders that will be impacted by system changes. Effective communication channels (i.e. facility intranets, board meetings, in services, list serves) for the distribution of information have been documented. Using data driven research, the communications plan will include an interactive, publicly available website containing DOH resources, a meeting calendar with materials, and a project timeline. Social media, TV and radio, and a provider toolbox containing staff education and resources will be developed. Additionally, NCI is creating customizable resources to meet the needs of each facility or target population.

***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.

To continue stakeholder and worker engagement, NCI's committees will review ongoing plans, thus ensuring they clearly support DSRIP activities and follow established guidelines, milestones and metrics. Additionally, the NCI Project Advisory Committee and Board of Managers will be kept apprised of all initiatives and progress, thus providing governing/advising authority to review, analyze, modify and approve project plans as deemed appropriate. Feedback will be summarized, documented and shared, and NCI's technological infrastructure will be leveraged to overcome geographical distance among participating providers, as the NCI region is one of the most sparsely populated, but geographically largest in NYS. Finally, transparency, communication and collaboration will be instrumental components of the NCI DSRIP initiatives to ensure successful implementation.

Section 5.8 - Domain 1 Workforce Process Measures:

Description:

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

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

Please click here to acknowledge the milestones information above.

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.

In order for the PPS to share data in an effective and confidential manner, the PPS' Health Information Technology Committee will maintain a comprehensive data sharing and confidentiality plan. All Partners having access to Protected Health Information (PHI) have agreed to sign the following required agreements:

Participation Agreement – Designed to ensure that participants comply with data sharing policies and procedures; explain the terms of the relationship, including roles, rights and responsibility of each party.

Business Associate Agreement – is a person or entity that performs certain activities involving the use or disclosure of protected health information on behalf of, or provides services to, a covered entity.

Data Use Agreement – A covered entity may use or disclose a limited data set if that entity obtains a DUA from the potential recipient.

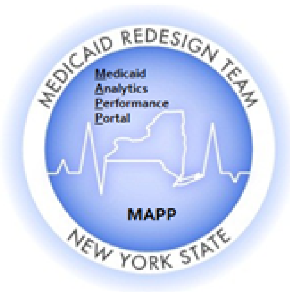
***Confidentiality 2:**

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

The data sharing and confidentiality plan encompasses a holistic risk management process which upholds all provisions of the HIPAA rule by incorporating the Administrative, Physical, and Technical safeguards and their respective Implementation Specifications into the PPS' and all partners' Information Security Policies and Procedures. As a part of this process, the PPS will perform Annual IT Risk Assessments of all partners having access to PHI to monitor adherence to the policies and procedures set forth to identify risks and develop mitigation plans. The PPS' data sharing tools also have detailed audit logs and built in mechanisms to identify inappropriate access to patient data. Any identified issues of inappropriate access will be reported to the Compliance Committee to determine appropriate actions.

***Confidentiality 3:**

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



The PPS will be able to share relevant information with all appropriate partners in real time using secure standards such as HL7 and Direct protocols, leveraging a combination of the existing HIE portal and results delivery systems. These same protocols allow the PPS to share information across New York State by leveraging the SHIN-NY. Partners with paper-based systems will be assisted to select and implement a compatible EHR and connect their system to the HIE. This technology will provide efficient care by reducing duplicate testing and unnecessary procedures. Necessary tests and procedures performed are communicated to the provider(s) in real-time to ensure proper follow up. The benefit of this efficient and effective system to the patient will be improved access to care, an enhanced patient-provider relationship, more regular health screenings and an increase in preventative care, ultimately resulting in better outcomes. What is paramount to ensuring the privacy of the patient's information, is the patient's ability to control access to their information by being given the opportunity to either consent or "opt-out" of the sharing of their information with the PPS. Patient privacy will be further protected by following the "need to know" principle and upholding all provisions of the HIPAA rule by incorporating the Administrative, Physical, and Technical safeguards. As a part of this process, the PPS will perform Annual IT Risk Assessments of all partners having access to PHI to monitor adherence to the policies and procedures set forth to identify risks and develop mitigation plans.

Section 6.2 – Rapid-Cycle Evaluation:

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

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

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

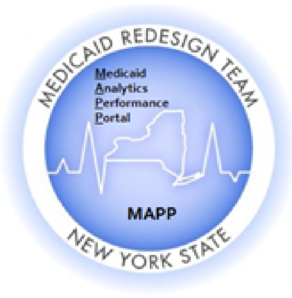
The NCI will utilize a Project Management Office that will exist within the NCI staffing structure and will include minimally a Project Management Officer, Chief Financial Officer, Data Analyst and staff accountant. The PMO will be accountable to gather project metrics and deliverables from each of the PPS partners related to specific projects as well as the organizational deliverables. These will be input into a project tracking software that will allow each partner to understand how they are performing and make corrective action. The PMO will report directly to the NCI leadership and to the NCI Board of Managers regarding process and organizational deliverables (Domain 1 and Domain 2) and to make recommendations on actions requiring attention or further investigation regarding PPS performance. The PMO will report to the Medical Management Committee on clinical outcomes metrics (Domain 3) and population health metrics (Domain 4). The Medical Management Committee will be responsible for reporting clinical outcome and population health metrics to the Board and for making recommendations actions requiring further investigation into PPS clinical and population health performance.

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

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

NCI, will use its MAPP PPS specific Performance Measurement Portal for the monitoring of performance on claims-based, non-Hospital CAHPS DSRIP metrics and DSRIP population health metrics. The Performance Portal will show our baseline performance, benchmarks, and the gap-to-goal targets per metric. NCI will monitor provider and organizational performance in a PPS-wide data registry to pro-actively identify areas of risk and/or underperforming providers. Quality assessment will be performed by the medical management committee The PMO will disseminate performance gaps to enable transparency and performance monitoring through proactive event alerts, control charts and reports that will inform business, operational and clinical improvements amongst all PPS partners. Performance data distributed to the governing body and project workgroups will inform improvement activities and identify opportunities for population-based activities to improve the health of a targeted population.

***RCE 3:**



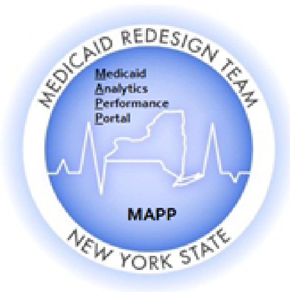
Describe the oversight of the interpretation and application of results (how will this information be shared with the governance team, the Providers and other members, as appropriate).

NCI's strong commitment to data sharing is evident in the monthly and weekly plans to capture data from the Performance Portal, NCI's disease registry, NCI's project management software and other sources. Once data is collected it will be reviewed by the appropriate committee's i.e. Medical Management committee monthly, and aggregated for review by the board of managers quarterly. NCI will produce reports specific to quality, finance, and progress towards metrics. NCI expects that all committees will review reports on a monthly basis so that the chair of each committee can provide a monthly summary to the NCI board of managers. NCI board of managers will conduct a complete thorough review of progress, quarterly and as suggested by the committees.

***RCE 4:**

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

NCI's rapid-cycle evaluation process uses a rigorous, scientific approach to provide NCI governance and partners with timely and actionable evidence of whether the DSRIP operational and clinical changes improve program outcomes. Changes will be tested in a matter of months, and providers can have a high degree of confidence in the results. RCE will inform and attain performance improvement goals by utilizing the Clinical Governance committee to disseminate leading practices and new evidence based interventions to inform PPS-level decision making and downstream provider workflows, process and clinical guidelines that transform our PPS to a highly integrated delivery system. Access to real time data improves NCI's ability to perform RCE and deliver information to our PPS partners and NCI governance for efficient and timely action. Project management with RCE will monitor and inform the transformation of the health care delivery system.



SECTION 7 – PPS CULTURAL COMPETENCY/HEALTH LITERACY:

Section 7.0 – PPS Cultural Competency/Health Literacy:

Description:

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

This section is broken into the following subsections:

7.1 Approach To Achieving Cultural Competence
7.2 Approach To Improving Health Literacy
7.3 Domain 1 - Cultural Competency / Health Literacy Milestones

Scoring Process:

This section is worth 15% of the total points available for the Overall PPS Structure Score. The responses will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.

7.1 is worth 50% of the total points available for Section 7.
7.2 is worth 50% of the total points available for Section 7.
7.3 is not valued in points but contains information about Domain 1 milestones related to these topics which must be read and acknowledged before continuing.

☑ Section 7.1 – Approach to Achieving Cultural Competence:

Description:

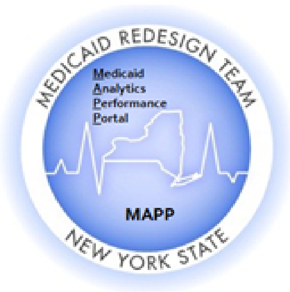
The National Institutes of Health has provided evidence that the concept of cultural competency has a positive effect on patient care delivery by enabling providers to deliver services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse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

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

***Competency 1:**

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

The Tug Hill Seaway region has little racial or linguistic diversity in the total population (92% white), even less in the population of Medicaid beneficiaries (93% white) and slightly more in the uninsured (85.83% white). Jefferson County has the most diversity (at 88% white) due to the presence of Fort Drum however that diversity is not reflected in Medicaid or uninsured numbers as the population of soldiers and families are insured by the military health benefit. There are three cultural competency challenges the PPS will need to address: 1) Socioeconomic - The issues that impacts this region the most significantly are socio-economic. The impact that living in poverty has on decisions and actions needs to be understood by those seeking to engage patients in their care. When a patient or family does not have a place to live, heat in their living space, access to transportation or enough food, it is reasonable for them to not be engaged in their care plan. The need to understand where a patient is coming from and going to is critical to the PPS success, 2) Generational – The majority of the regions Medicaid beneficiaries and uninsured are under the age of 44, yet the significant proportion of physicians and other healthcare professionals in the region are over the age of 50. Fundamental value and communication differences often exist between those of different generations. Understanding these values and communication means will help understand differences that may arise in the healthcare environment, 3) Cultural variations between the physician population of the region and the residents of the region – while the region's population has very little cultural diversity, the regions physician population is very culturally diverse, thus large populations of patients are impacted by cultural competency challenges.



***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 North Country Initiative will integrate cultural competency along with health literacy directly into its organizational structure. NCI will establish a committee of members to oversee and assist member organizations to implement best practices regarding cultural and linguistic competence and health literacy. This committee, with guidance from the compliance committee and the NCI Board of Managers, will establish contracts with community-based organizations to work within practices located in "hot spots" on measurements of, and improvements in, health literacy and cultural competency. NCI member providers will agree to adopt policies and procedures to improve cultural and linguistic competence to better provide care for members of diverse groups including generational and socioeconomic understanding. After an assessment from the contracted organizations, communication materials will be provided in a manner and in language that improves understanding and adherence for patients, with the goal of improving health outcomes. Member providers will agree to continual assessments using their own demographic data, to ensure training for executive team and frontline workers is retained and cultural and linguistic competence becomes integral to the member provider. It is the assumption of NCI that the Health Literacy Committee will evaluate and assess the community composition and demographics for member providers and look for trends, examining and using data to document such trends and disparities related to culture, age, gender, language, race and ethnicity and recommend training that will be implemented for all front-line workers with more intensive training required for all care management/care coordination positions.

***Competency 3:**

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

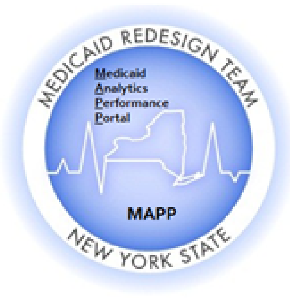
Participating members will receive cultural and linguistic training from contracted community-based advocacy organizations, on how best to promote good health, prevention and treatment among people with MEB disorders. NCI member providers will agree to adopt policies and procedures to improve cultural and linguistic competence to better provide care for members of diverse groups. After an assessment from the contracted organizations, communication materials will be provided in a manner and in language that improves understanding and adherence for patients, with the goal of improving health outcomes. Member providers will agree to continual assessments using their own demographic data, to ensure training is retained and cultural and linguistic competence becomes integral to the member provider. It is the assumption of NCI that the Health Literacy Committee will evaluate and assess the community composition and demographics for member providers and look for trends, examining and using data to document such trends and disparities related to culture, age, gender, language, race and ethnicity.
The contract requirements will include assistance to member providers on establishment of goals to update and provide on-going guidance and continued information-sharing for staff, identification of community resources such as peer-run agencies, self-help groups and culture specific community groups that could be of assistance. North Country Initiative's vision of cultural competence is to:
Develop effective service delivery that includes input from culturally diverse com¬munities and individuals
Expand employees' cultural competence and adapting services to meet culturally unique needs
Apply strategies to mediate and resolve conflicts and misunderstandings that stem from cultural differences
Advocate for and supporting culturally competent and responsive programs
Measure the impact that services have on culturally diverse populations
Perform regular and continuous self-assessment

☑ Section 7.2 – Approach to Improving Health Literacy:

Description:

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

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



***Literacy:**

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

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

North Country Initiative will integrate cultural competency and health literacy directly into its organizational structure. NCI will establish a committee of members to oversee and assist member organizations to implement best practices regarding cultural and linguistic competence and health literacy. This committee with guidance from the compliance committee and the NCI Board of Managers will establish contracts with community-based organizations to work within practices located in "hot spots" on measurements of, and improvements in, health literacy and cultural competency. Currently there are three CBO's being considered: Northern Regional Center for Independent Living, Step-by-Step and the Mental Health Association. Cultural and linguistic considerations include but are not limited to: ethnicity, race, age, gender identity, primary language, English proficiency, sexual orientation, immigration status, spiritual beliefs physical abilities and limitations, family roles, limited literacy, employment and socioeconomic factors. The chosen CBO's will work with member organizations to ensure focus on cultural considerations in service design and delivery, establishment of community-based networks and inclusion of natural supports. A key feature for participating NCI Member organizations will be the adoption of a policy and practice regarding cultural competency and health literacy relative to the populations they serve. Further, participating members will receive cultural and linguistic training from community-based advocacy organizations, on how best to promote good health, prevention and treatment among people with MEB disorders. NCI member providers will agree to adopt policies and procedures to improve cultural and linguistic competence to better provide care for members of diverse groups. After an assessment from the contracted organizations, communication materials will be provided in a manner and in language that improves understanding and adherence for patients, with the goal of improving health outcomes. Member providers will agree to continual assessments using their own demographic data, to ensure training is retained and cultural and linguistic competence becomes integral to the member provider. It is the assumption of NCI that the Health Literacy Committee will evaluate and assess the community composition and demographics for member providers and look for trends, examining and using data to document such trends and disparities related to culture, age, gender, language, race and ethnicity.

The contract requirements will include assistance to member providers on establishment of goals to update and provide on-going guidance and continued information-sharing for staff, identification of community resources such as peer-run agencies, self-help groups and culture specific community groups that could be of assistance. North Country Initiative's vision of cultural competence is to:

Develop effective service delivery that includes input from culturally diverse com¬munities and individuals
Expand employees' cultural competence and adapting services to meet culturally unique needs
Apply strategies to mediate and resolve conflicts and misunderstandings that stem from cultural differences
Advocate for and supporting culturally competent and responsive programs
Measure the impact that services have on culturally diverse populations
Perform regular and continuous self-assessment

☑ 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.

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.

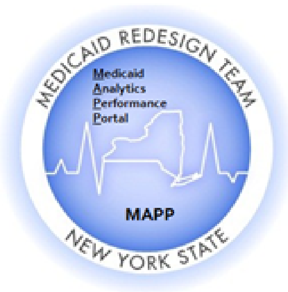
North Country Initiative's board of managers, finance committee and Project Advisory Committee (PAC) has reviewed and approved the proposed flow of funds. NCI's funds flow was created around meeting four objectives; fund the implementation costs to meet the projects chosen, incentivize performance, supplement revenue loss and allow flexibility. The total expected DSRIP dollars used to determine allocation was based upon a calculation of the total number of projects, project index score, estimated valuation benchmark, number of expected attributed lives, estimated plan application score and duration. The NCI Distribution of funds plan is as follows:

Cost of Project Implementation 46%: Split into two categories 1) project implementation costs, project management office and administration, workforce/training and other PPS wide costs 2) costs of services needed to successfully carry out projects but not currently covered. Note: 10% of the 46% will be used to recruit providers due to severe PC shortages as NCI transitions DY5 this will move into Bonus.

PPS Provider Incentive Payments 20%: Split into two categories 1) Incentive to all PPS members if the overall goal of DSRIP is achieved to build shared mission 2) Incentives for achieving project specific outcomes. The investment, impact and contribution by type in the delivery and performance of DSRIP projects will drive incentives by each clinical specialty, Safety Net provider, or community based organization. This could include any of the range of services along the care continuum, SNFs, LTACS, Home Care, CBOs, ACFs, ALPs, care management, behavioral health care, primary care and specialists.

Revenue Loss 20%: Split into two categories 1) temporary specific tied to DSRIP (re)admissions & ER reductions 2) temporary distressed provider assistance tied to restructure and stability metrics

Other: 14%: Split into three categories 1) Contingency to provide for unknown variables 2) Innovation to develop or reward bright ideas that work 3) High performance to reward those going above and beyond and exceeding outcome deliverables.



Distribution of funds will be managed and approved through the governing body and its committees under the financial management capability of the Lead entity. The representation of all providers and clinical specialties within the governance structure and committees ensures that DSRIP funds flow to the appropriate projects and finally to those providers responsible for achieving the goals for each of the DSRIP projects as well as for the overall DSRIP initiative. As a safeguard to make sure decisions are appropriate and informed properly a PMO office is being established that will utilize DSRIP specific project management software. This software will allow the PMO office to monitor the appropriate use of funds and ensure that funds are being allocated properly amongst the PPS.

NCI's funds flow was created around meeting the four objectives (fund implementation costs, incentivize performance, supplement revenue loss, and flexibility) that will have the greatest impact on realizing DSRIP goals. The budget fully represents those objectives while maintaining NCI's ability to course correct for unforeseen circumstances. NCI is confident that by meeting the budget objectives and ensuring transparency in the budget process, NCI and its PPS partners successful achieve DSRIP goals.

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.

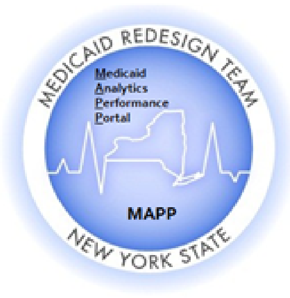
#	Budget Category	Percentage (%)
1	Cost of Project Implementation	46%
2	Revenue Loss	20%
3	Internal PPS Provider Bonus Payments	20%
4	Other	14%
	Total Percentage:	100%

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

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

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

☑ Please click here to acknowledge the milestones information above.



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:**

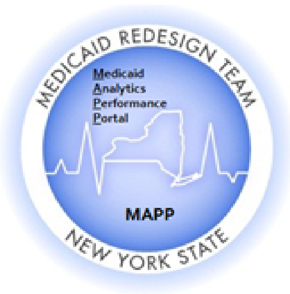
Describe the assessment the PPS has performed to identify the PPS partners that are currently financially challenged and are at risk for financial failure.

The NCI completed a high level analysis during the community needs assessment which included identifying those PPS partners whose operations would be negatively impacted by successful reductions in DSRIP targeted utilization and whose failure would be disruptive to achievement of DSRIP goals and PPS success. The PPS then utilized the NCI existing governance structure to engage those providers which included the six safety net participating hospitals with in-patient capabilities.

Those partners than completed a comprehensive financial spreadsheet to inform both the financial sustainability assessment and to inform the metrics by which the providers will receive revenue loss payments and payments related to meeting financial stability metrics and milestones. The PPS compiled financial and income data, financial and operational metrics, statistics related to payer mix and utilization trends by inpatient and outpatient service line, as well as sources of other gap funding such as Medicare DSH, IAAF, HEAL, VAP, indigent and other.

This data was then used to perform a sensitivity analysis of the impact of a 25% reduction in DSRIP sensitive admissions and emergency room visits and a liquidity ratio analysis to identify those that are currently distressed or could, based on current status become so, due to successful achievement of DSRIP activities.

***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.

Safety net hospitals and other primarily inpatient providers will be negatively impacted by DSRIP goals. This varies for each of the NCI safety net hospitals based on their current service lines and other business impacts. Those who have been moving toward an out-patient focus, growing prevention service lines of business and streamlining non-clinical processes in recent years will be better positioned to absorb these changes. Others are in this process and will have the greatest potential for sustainability within the integrated delivery system and with a specific plan to address the changing model.

The other expected impact will be on those providers that are currently receiving IAAF funds through DSRIP or have historically received other bridge money or guarantees through DSH and other awards. Currently the NCI has three of the six safety net hospitals are receiving IAAF funds and all of the participating hospitals have received either VAP or HEAL funds in recent years. The primary expected financial impacts will be:

- Reduction in avoidable (re)admissions and emergency department use impacting payer mix and cost structure
- Short term reductions in cash due to loss of support payments or reduced reimbursements
- Higher short term costs to restructure services and retraining employees during the implementation phase

The NCI has made provisions in the budget and funds flow plan to provide support for these expected impacts, as well as other items such as workforce recruitment workforce recruitment and retraining and non-reimbursable services required to carry out DSRIP project plans and to support the distressed Safety Net providers who are financially challenged and critical to the delivery of DSRIP outcomes. These provision will be tied directly to implementing changes and improving financial stability metrics.

☑ 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:**

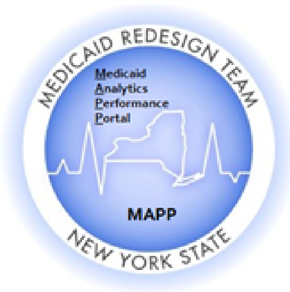
Describe the plan the PPS has or will develop, outlining the PPS' path to financial sustainability and citing any known financial restructuring efforts that will require completion.

The NCI will develop a Financial Sustainability Plan during the implementation and start-up of the PPS. The plan will be developed with oversight of the Finance Committee and will be presented to the NCI Board of Managers for approval. Financial stability requires a sound business plan with key milestones to attain healthy financial and operational metrics. The restructuring efforts are currently underway or will be underway at identified distressed IAAF funded facilities or potentially distressed facilities:

- Carthage Area Hospital is in the process of forming a formal affiliation with Samaritan Medical Center under NYS DOH oversight.
- River Hospital is growing outpatient service lines and identifying potential new opportunities with Claxton Hepburn Medical Center to support DSRIP objectives
- Massena Memorial Hospital, one of only two local municipally owned hospitals in NYS, is owned by the town of Massena and at this time the Massena board is exploring privatizing the facility due to the unsustainable losses being experienced. (Note: the other local municipally owned is Lewis County General, which is also in the NCI service region but is participating in the CNY DSRIP)
- Clifton-Fine Hospital, while not currently distressed, has received VAP and other gap funding in recent years. Clifton-Fine is currently affiliated through a passive-parent arrangement with Samaritan Medical Center.

Each provider identified as being financially distressed or fragile will develop specific plans during the implementation phase with milestones and metrics and time frames defined. These plans will focus on expense reduction, restructure of debt, re-allocation of resources and service line changes to meet DSRIP goals and financial sustainability. The NCI will engage Faust Charles, a financial auditing firm to assist with the development of these metrics and milestones and engage a strategic financial planning firm to lead high level PPS –wide plan.

The PPS Project Management Officer will provide ongoing reports from each provider and provide these to the PPS Finance Committee. PPS Finance Committee will monitor ongoing financial metrics for all potentially distressed providers and report on metrics to the



Executive Board.

***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.

Each distressed provider's specific plan developed during the implementation phase will have milestones and metrics and time frames defined. These plans will be put into a Project Management software application that will provide reports on gap to goals per metric.

The NCI Project Management Officer will provide these reports back to the provider and will provide ongoing reports from each provider to the PPS Finance Committee. The PPS Finance Committee will monitor the ongoing financial metrics for all potentially distressed providers and report on metrics to the Executive Board.

In addition to the providers identified during the initial surveys as being distressed or financially fragile, the PPS will monitor the financial status of providers going forward as part of the financial sustainability plan. The funds plan provides needed support for fragile safety net providers and other distressed providers. If any provider indicates a trend that could impact their financial stability, those will also be placed under a Distressed Provider Plan

***Path 3:**

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

The NCI has been and will continue to develop during the DSRIP timeline into a highly integrated delivery system with population health management capability. This capability will prepare the NCI for working on value based models. The NCI has already begun preliminary conversations with one of the two Medicaid managed care providers serving the region. In addition, NCI as the sole Member of Healthcare Partners of the North Country, has been awarded a Medicare Shared Savings Program Accountable Care Organization. These activities will ensure that the capabilities developed through DSRIP will create a financially sustainable model that moves beyond the DSRIP program and sustains the DSRIP outcomes.

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

Description:

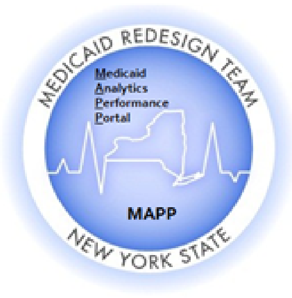
Please describe the PPS' plan for engaging in payment reform over the course of the five year demonstration period. This narrative should include:

***Strategy 1:**

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.

It has been the vision of the North Country Initiative since its inception to realize sustainable transformation of the delivery system to improve quality, reduce cost of care and better serve patients, through activities that lead to a better quality of life for those with chronic disease, and prevent the onset of disease in the total population. To sustain this vision requires that the PPS work in partnership with MCO's for payment reform so that payers and providers share in savings generated by improved care and aligns incentives with outcomes. NCI is committed to transforming to value-based reimbursement, creating a payment system that is transparent, fair, and increases the quality of NCI health services, while rewarding high performance. NCI recognizes that our strategy must be scalable and flexible to allow all networks providers, who are in various stages of readiness, to participate in payment reform. There are two Medicaid Managed Care (MMC) serving our communities. We have already engaged one of these and will continue to engage with the MMCs to develop a plan for evolving payment models that include both service specific for subpopulations and for shared savings based on total attributed population.

NCI PPS partners have experience with population health initiatives and have participated in various insurance pay for performance initiatives. In addition, the NCI was recently awarded an MSSP ACO. These experiences create the knowledge and processes to capably utilize the DSRIP program to incrementally evolve in to value based contracting.



***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 transformation through DSRIP will drive down the cost of care on a per member basis. This creates opportunity for total attributed population shared savings programs and for specific targeted population interventions. The development to advanced primary care through Patient Centered Medical Home (PCMH) and the development and expansion of disease registry population health management capability give the PPS significant ability to impact positive patient outcomes and to risk stratify for populations for targeted interventions. This capability will assist the PPS to take a staged approach, beginning in year two with upside-only contracting and evolving over time to more upside and downside contracting as the PPS is strengthened and learns how to effectively impact improved patient outcomes and reduce costs. This evolution of payment transformation will allow for the DSRIP stabilization of providers upfront being replaced by payer strategy that creates a sustainable financial model for the PPS and the fragile safety net providers.

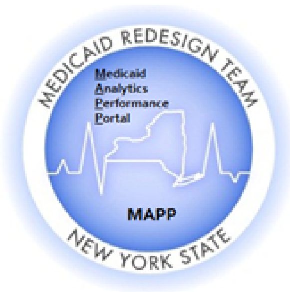
Section 9.4 - Domain 1 – Financial Sustainability Plan Milestones:

Description:

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

- Completion of a detailed implementation plan on the PPS' financial sustainability strategy (due March 1st, 2015); and
- Quarterly reports on and documentation to support the development and successful implementation of the financial sustainability plan.

☑ Please click here to acknowledge the milestones information above.



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.

North Country Initiative has a proven track record of success. This success is evident throughout the initiatives of the past. The region, NCI and our PPS lead has had multiple levels of success within population health management, listed below are a few examples.

Heal 10 project that targeted the COPD population reducing COPD exacerbation across the region and included PCMH recognition, HIE connectivity and Disease registry development.
Diabetes Recognition Program - 22 primary providers were recognized through the NCQA DRP
Successful participation in Rewarding Physician Excellence in Diabetes program through Excellus
Samaritan Medical Center (lead entity) recognized as a Hospital Health Home through their focus on discharges and primary care follow up and sepsis management
NCI was recently accepted as a 2015 Medicare Shared Saving Program ACO.

These are a few examples of this regions commitment to population health management and the success in implementing projects across the region.

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 Iroquois Healthcare Association (IHA) is a proven and experienced organization ready to support implementation of NCI PPS workforce strategy. IHA has successfully collaborated with hospitals, nursing homes and home care agencies across Upstate on a variety of workforce recruitment, retention, and training initiatives. IHA has demonstrated success in identifying eligible candidates for training programs, organizing appropriate trainings, and assisting with retention and employment for trained individuals in the health care sector. IHA has successfully administered over $24 million in federal and state grant projects training over 9,000 health care workers over the past 16 years including Health Workforce Retraining Initiatives (DOH), TANF Health Worker Retraining Initiatives (DOH), Emerging and Transitional Worker Training Initiative (DOL), and Strategies to Assist Workers Impacted by the Berger Commission (DOL). IHA has collaborated with national and regional partners to deliver both online and classroom training. IHA has worked with AHECs on past projects and will seek continued collaboration with the Northern Area Health Education Center, an active and current partner of the NCI PPS to ensure coordination of programs.

IHA has existing infrastructure as well as policies and procedures in place to meet expected DSRIP metrics including technology, communication systems, workforce data collection, and distance learning capabilities. An existing centralized database provides the ability to track and monitor participant, and program performance. IHA is committed to manage, implement and assure timely completion of the workforce strategy by dedicating experienced, NYS pre-qualified personnel.

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.

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

Primary Lead Provider Name: SAMARITAN MEDICAL CENTER
Secondary Lead Provider Name:

Lead Representative:	Thomas H Carman
Submission Date:	12/22/2014 03:15 PM

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