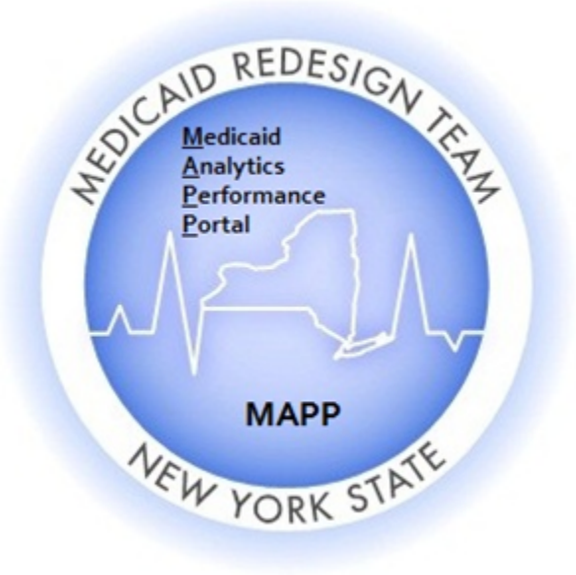
New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP PPS Organizational Application



United Health Services Hospitals, Inc

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

DSRIP PPS Organizational Application

United Health Services Hospitals, Inc (PPS ID:44)

TABLE OF CONTENTS:

United Health Services Hospitals, Inc (PPS ID:44)

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United Health Services Hospitals, Inc (PPS ID:44)

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: **44_SEC000_UHSH_dsrip_financial_stability_test_08_31_2014.pdf**

Description of File

File Uploaded By: bp442300
File Uploaded On: 12/18/2014 03:47 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: bp442300
Last Updated On: 12/22/2014 12:39 PM

Certified By: rk442298
Certified On: 12/22/2014 12:41 PM
Unlocked By:
Unlocked On:
Lead Representative: Robin Marie Kinslow-Evans

United Health Services Hospitals, Inc (PPS ID:44)

SECTION 1 – EXECUTIVE SUMMARY:

Section 1.0 - Executive Summary - Description:

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

Scoring Process:

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

Section 1.1 - Executive Summary:

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

#	Goal	Reason For Goal
1	Create an Integrated Delivery System (IDS)	The current healthcare system has functioned in silos leaving the intricacies of care coordination with the Medicaid beneficiary which has led to current health and utilization outcomes. The creation of an IDS will provide population health and care coordination services for Medicaid beneficiaries creating the opportunity for care that is timely, patient centered, and cost effective. Care Coordination will avoid duplication of services and assure that all providers involved with a beneficiary's care have a full picture of their needs and can coordinate the care plan to maximize outcomes. An IDS is the unifying structure for all the PPS Projects and will optimize the ability of the PPS' to achieve overall DSRIP goals. Measures marking success in attaining this goal include the number of providers actively sharing EHR systems, number of providers who achieve PCMH certification and number of contracts with Medicaid Managed Care Organizations.
2	Cost effective utilization	Medicaid data reveals opportunity to improve high cost utilization through decreasing ED visits and to a lesser extent, decreasing avoidable admissions. Medicaid beneficiaries participating in CNA focus groups commented they often usedED services, and numerous reasons were cited including:lack of access to other options;transportation, child care and financial access issues; perceptions of lower quality of care in other settings,and;the convenience of ERs as a one-stop shop. The IDS infrastructure and Projects will address these issues through patient engagement, education, care coordination, care management and other efforts focused on building connections to community based care. Tracking patient engagement, referrals for navigation and case loads of care managers will be useful progress measures. Measuring overall system impacts using SPARCS, PQRI, clinical and claims data about utilization linked to financial data will also be used.
3	Workforce Transformation	The redesign of the care delivery system will decrease the need for acute care professionals and increase the need for these professionals within the community. Therefore a method to redeploy the workforce will be necessary. The transition from acute care to community based care will require a workforce with skills in delivering care in non-acute environments and competency in patient engagement and community outreach. A workforce strategy that ensures the right people, with the right skills, in the right place, at the right time, and at the right cost is essential for effective care delivery transformation and ultimately achievement of DSRIP goals. Success in transforming the workforce can be measured by the number of

United Health Services Hospitals, Inc (PPS ID:44)

#	Goal	Reason For Goal
		training programs developed, number of workers trained, number of positions filled in the newly created community positions, and number of positions decreased in the acute care setting.
4	Ensure sustainability	STRIPPS will create processes to preserve safety net providers while transitioning health care delivery and payment models. Moving towards value based payment requires the application of population health analytics and customized care coordination resources for appropriate utilization of services and containment of costs. DSRIP funds will support the safety net providers in the transitioning environment and provide funding to implement the Projects. In order to be financially sustainable by the end of DY5, institutional providers must lower their cost structure as utilization shifts to community based organizations.Redesigning business systems and analytics, and progressively shifting to value based payment models are essential. Accurate accounting of monies received and distributed, deliberative and reasoned decision making in projecting budgets, and monitoring financial trends are critical measures to ultimately achieve sustainability beyond DSRIP funding.
5	Cost effective utilization	Medicaid data reveals opportunity to improve high cost utilization through decreasing ED visits and to a lesser extent, decreasing avoidable admissions. Medicaid beneficiaries participating in CNA focus groups commented they often usedED services, and numerous reasons were cited including:lack of access to other options;transportation, child care and financial access issues; perceptions of lower quality of care in other settings,and;the convenience of ERs as a one-stop shop. The IDS infrastructure and Projects will address these issues through patient engagement, education, care coordination, care management and other efforts focused on building connections to community based care. Tracking patient engagement, referrals for navigation and case loads of care managers will be useful progress measures. Measuring overall system impacts using SPARCS, PQRI, clinical and claims data about utilization linked to financial data will also be used.
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7	Ensure sustainability	STRIPPS will create processes to preserve safety net providers while transitioning health care delivery and payment models. Moving towards value based payment requires the application of population health analytics and customized care coordination resources for appropriate utilization of services and containment of costs. DSRIP funds will support the safety net providers in the transitioning environment and provide funding to implement the Projects. In order to be financially sustainable by the end of DY5, institutional providers must lower their cost structure as utilization shifts to community based organizations.Redesigning business systems and analytics, and progressively shifting to value based payment models are essential. Accurate accounting of monies received and distributed, deliberative and reasoned decision making in projecting budgets, and monitoring financial trends are critical measures to ultimately achieve sustainability beyond DSRIP funding.

United Health Services Hospitals, Inc (PPS ID:44)

***Formulation:**

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

The healthcare delivery transformation effort that became STRIPPS was centered on an analysis of utilization and existing community need assessment data that revealed patterns in utilization and health status among Medicaid beneficiaries. To gain insight into those trends, a comprehensive community assessment was conducted. Armed with a deeper understanding of community need, DSRIPProjects were selected to address the gaps and missing elements in care delivery. The 11 projects selected align with health priorities, NYS DOH Prevention Agenda, and take into consideration the healthcare disparities among urban/rural populations. The Projects are synergistic and build on existing community strengths.

STRIPPS is supported by an active/engaged PAC with broad representation. With each milestone of development, STRIPPS leadership has consulted and gained approval from the PAC. This approach has fostered trust among PAC members, facilitated partnerships between organizations and created a collaborative network of providers who are prepared and motivated to achieve DSRIP goals.

***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.

At the conclusion of the five year DSRIP program, the Medicaid delivery system will have shifted a significant amount of capacity from acute care and institutional settings into community based settings that are regionally coordinated and supported by a shared IDS infrastructure. With additional impacts from other payors, the provider entities will likely have experienced some consolidation, with institutional providers shifting resources into community based care with more efficient organizational models and less fragmentation. The IDS will have matured into a high performing organization with core competencies in outreach and navigation services, population heath analytics, care coordination, IT connectivity, clinical performance management functions and financial management systems. The resulting IDS and the associated delivery system would be well positioned for partnering with a payor organization on risk based payment.

***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	COPA PHL 29F and proposed regulations	The regulatory relief requested is approval of Certificate of Public Advantage (COPA) pursuant to PHL 29F and in accordance with newly promulgated regulations. The projects requested for are: 2.a.i.; 2.b.iv.; 2.b.vii.; 2.c.i.; 2.d.i.; 3.a.i.; 3.a.ii.; 3.b.i.; 3.g.i.; 4.a.iii.; and 4.b.ii. as the components of the various projects require creation of a clinically integrated delivery system and collaborations among providers which may impact market share and competition through a coordinated plan to promote efficiencies and reduce

United Health Services Hospitals, Inc (PPS ID:44)

#	Regulatory Relief(RR)	RR Response
		cost of health care delivery. The PPS requires broad state action immunity antitrust protection in order to implement the project requirements imposed by the state. The alternatives is to comply with federal and state law as it is not clear that state action immunity applies to the DSRIP program activities of the PPS. The PPS also believes that the activities it plans to implement do not violate the law and meet the rule of reason test, however it has determined that immunity is necessary to remove impediments and avoid legal costs and protracted discovery if an action is commenced against the PPS, the lead entity or any partner organization. The PPS has determined that immunity is a condition to proceeding with DSRIP on April 1, 2015 and will be submitting an application in the form provided by DOH for COPA approval. This is an issues relating to antitrust under state and federal law and does not pertain to patient safety and poses no risk to patient safety. The PPS intends to provide antitrust compliance training to the PPS staff and partner organizations.
2	(Establishment) 10 NYCRR 405.1 (c)	The regulation requested for waiver is 10 NYCRR 405.1 (c). The projects requested for are: 2.a.i.; 2.b.iv.; 2.b.vii.; 2.c.i.; 2.d.i.; 3.a.i.; 3.a.ii.; 3.b.i.; 3.g.i.; 4.a.iii.and 4.b.ii. to exempt the PPS/Newco from the requirement of becoming an established operator as it carries out its role in governing the PPS, creating collaborative arrangements and approving protocols that impact the delivery of services. There are no alternatives to this if DOH believes that the activities of the PPS/Newco would require establishment as an operator. The impact on patient safety potentially arises in the development and implementation of clinical pathways and protocols which influence how care is provided. Waiver of the regulation for establishment, however, and any potential impact on patient safety, will be mitigated by the PPS and Newco by having clinical experts develop the protocols and clinical pathways based on evidence-based practice and standards of care. The partner organization facilities will need to adopt the protocols and pathways through the shared governance structure of the PPS or otherwise authorized to perform clinical services and the activities of the PPS are under the oversight of the DOH through the DSRIP program and will include quality assurance and quality improvement monitoring and reporting. Also, all of the providers of services are licensed and will remain independently authorized and required to exercise clinical judgment to ensure high quality patient care and to avoid patient risk.
3	(Establishment) 10 NYCRR 600.9	The regulation requested for waiver is 10 NYCRR 600.9. The projects requested for are: 2.a.i.; 2.b.iv.; 2.b.vii.; 2.c.i.; 2.d.i.; 3.a.i.; 3.a.ii.; 3.b.i.; 3.g.i.; 4.a.iii. and 4.b.ii. to exempt the PPS/Newco from the requirement of becoming an established operator as it carries out its role in governing the PPS, creating collaborative arrangements and approving protocols that impact the delivery of services. There are no alternatives to this if DOH believes that the activities of the PPS/Newco would require establishment as an operator. The impact on patient safety potentially arises in the development and implementation of clinical pathways and protocols which influence how care is provided. Waiver of the regulation for establishment, however, and any potential impact on patient safety, will be mitigated by the PPS and Newco by having clinical experts develop the protocols and clinical pathways

United Health Services Hospitals, Inc (PPS ID:44)

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		based on evidence-based practice and standards of care. The partner organization facilities will need to adopt the protocols and pathways through the shared governance structure of the PPS or otherwise authorized to perform clinical services and the activities of the PPS are under the oversight of the DOH through the DSRIP program and will include quality assurance and quality improvement monitoring and reporting. Also, all of the providers of services are licensed and will remain independently authorized and required to exercise clinical judgment to ensure high quality patient care and to avoid patient risk.
4	(Revenue Sharing) 10 NYCRR 600.9 (c)	The regulation requested for waiver is 10 NYCRR 600.9 (c). The projects requested for are: 2.a.i.; 2.b.iv.; 2.b.vii., 2.c.i.; 2.d.i.; 3.a.i.; 3.a.ii.; 3.b.i.; 3.g.i.; 4.a.iii. and 4.b.ii to ensure that the aspects of DSRIP activities which involve distribution of revenue and collaborative arrangement among providers does not violate this regulation which prohibits regulated entities from fee-splitting or sharing in gross revenues of non-established entities. This has been identified as a potential impediment to the flow of funds through the PPS as part of the DSRIP project and a waiver is requested with respect to the financial components of any agreements or other processes providing for the flow of funds with non-established operators since the PPS, Newco and Partner Organizations, may share in distribution of DSRIP funding as part of sharing a patient population and participating in the DSRIP projects. It is important to distinguish this in a manner that it does not constitute illegal fee-splitting with non-established providers. There are no alternatives to waiver if this would be considered to implicate the prohibition on fee-splitting. Patient safety is not impacted because the governance structure will ensure that services are provided in conformance with scope of practice and standards of the professions by qualified and licensed providers regardless of funds flow within the PPS.
5	(Corporate Practice of Medicine) Request determination	The prohibition on the corporate practice of medicine may raise a concern since corporations may not employ licensed professionals to practice medicine, and accordingly, while not a regulatory waiver request, we request DOH to acknowledge, in consultation with Department of Education, that PPS activities do not constitute the corporate practice of medicine under Educ. Law 6522 which provides that only a person licensed or otherwise authorized under Education Law shall practice medicine and 6527 which provides that a non-profit medical or dental expense indemnity corporation or a hospital service corporation may employ licensed physicians. DOH and Department of Education should determine that PPS activities do not constitute the corporate practice of medicine. All projects are requested for waiver since the PPS and partner organizations will need to enter into collaborative arrangements with physicians to implement PPS-approved care protocols and referral practices. There are no alternatives and patient safety is not impacted because physician fees for professional services will not be shared with non-physicians who are affiliated with the provider and the governance structure will ensure that services are provided in conformance with scope of practice and standards of the professions by qualified and licensed providers regardless of funds flow within the PPS. Patient safety is not impacted.

United Health Services Hospitals, Inc (PPS ID:44)

#	Regulatory Relief(RR)	RR Response
6	(HIT) 10 NYCRR 401.3 (a)	The regulation requested for waiver is 10 NYCRR 401.3 (a). The projects requested for are: 2.a.i.; 2.b.iv.; 2.b.vii.; 2.c.i.; 2.d.i.; 3.a.i.; 3.a.ii.; 3.b.i.; 3.g.i.; 4.a.iii.and 4.b.ii. to facilitate rapid implementation in preparation for commencing DSRIP Y1, as all partner organizations and Newco must be in a position to make rapid changes in HIT. All of these projects require the expanded use of HIT technologies and interoperability, which will require investment in new EHR technologies, outlay of capital and the provision of vendor services. The reasons for the waiver request are to relieve the PPS and all partners from seeking further review or approval from the DOH regarding HIT acquisition, installation, modification or outlay of capital to implement necessary technology advances to participate in DSRIP projects. No alternatives were identified due to the fundamental requirements of DSRIP for data collection, sharing and reporting and also the priority to implement collaborative objectives to integrate care and ensure technologic infrastructure for providers to be interoperable and working in uniformity to promote the objectives of DSRIP. This provision does not negatively impact patient safety and would not risk patient safety since HIT systems that will be utilized will meet all prevailing HER standards and be certified to promote meaningful use objectives of providers. Also it is important to note that integrating patient records and increasing electronic access improves patient safety and assist in quality data extraction which is fundamental to the quality assurance and quality improvement activities of the PPS.
7	(HIT) 10 NYCRR 710.1 (c) (2), (3)(i)(j and q), (5) (iv)(g)	The regulation requested for waiver is 10 NYCRR 710.1 (c) (2), (3)(i)(j and q), (5) (iv)(g). The projects requested for are: 2.a.i.; 2.b.iv.; 2.b.vii.; 2.c.i.; 2.d.i.; 3.a.i.; 3.a.ii.; 3.b.i.; 3.g.i.; 4.a.iii. and 4.b.ii. to facilitate rapid implementation in preparation for commencing DSRIP Y1, as all partner organizations and Newco must be in a position to make rapid changes in HIT. All of these projects require the expanded use of HIT technologies and interoperability, which will require investment in new EHR technologies, outlay of capital and the provision of vendor services. The reasons for the waiver request are to relieve the PPS and all partners from seeking further review or approval from the DOH regarding HIT acquisition, installation, modification or outlay of capital to implement necessary technology advances to participate in DSRIP projects. No alternatives were identified due to the fundamental requirements of DSRIP for data collection, sharing and reporting and also the priority to implement collaborative objectives to integrate care and ensure technologic infrastructure for providers to be interoperable and working in uniformity to promote the objectives of DSRIP. This provision does not negatively impact patient safety and would not risk patient safety since HIT systems that will be utilized will meet all prevailing HER standards and be certified to promote meaningful use objectives of providers. Also it is important to note that integrating patient records and increasing electronic access improves patient safety and assist in quality data extraction which is fundamental to the quality assurance and quality improvement activities of the PPS.
8	(Add capacity/relocate) 10 NYCRR 401.3 (a and e)	The projects requested for are: 3.a.i., 3.a.ii., 3.g.i. and 4.a.iii, and may be supplemented as project teams work on implementation design plans, to

United Health Services Hospitals, Inc (PPS ID:44)

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		facilitate the addition or expansion of services and capacity to meet DSRIP goals. The reason for the waiver requested is to enable the PPS to promote rapid system reconfiguration for implementation of these projects as envisioned in the DSRIP projects submitted, to transform the delivery of services to be integrated and collaborative and expand the ability to meet patient needs in alternative locations such in primary care sites and elsewhere in the community to reduce the reliance on ED and inpatient hospital care. All of these projects require the expansion of capacity or adding or changing existing services, including also relocating services, in some respect by partners implementing the projects. Projects 3.a.ii. and 4.a.iii.for example are aimed to expand the ability to meet the needs of patients in a more comprehensive and collaborative manner so that medical and behavioral care needs are assessed and treated with streamlined access and by implementing collaborative methods including but not limited to IMPACT. The addition of services and capacity may be by primary care and/or behavioral health providers, as determined by whether they pursue implementation through a single provider approach or by co-locating and integrating with other licensed providers in shared space. Project 3.a.i. will require increasing or adding crisis mobilization and stabilization services and locating the provision of such services in alternate locations in the community. Project 3.g.i. will require adding palliative care services in primary care sites and this will expand the capacity of the primary care providers to care for more patients and will expand the scope of services to include palliative care through partnerships with other providers, including Hospice providers. The request for waiver is to relieve the requirements of the need for new CONs and application of assessing need methodology for determination of public need and prior review and approval and in the alternative, for DOH to determine that these elements of the required determinations, review and approval have been satisfied upon approval of the DSRIP Project application and upon PPS notice to DOH of such changes in capacity and service prior to implementation. The alternative considered by the PPS is that if prior review is going to be required to request that DOH only require limited review. We ask this as alternative relief. This waiver will not adversely impact patient safety and is not a patient safety risk because the providers involved are regulated for the provision of care and DOH will receive ample notice of the changes that will be implemented with specificity as to which providers will be collaborating and how the services will be reconfigured. The PPS will oversee the design and implementation of these services.
9	(Add capacity/service) 10 NYCRR 670.1 (a-c)	The regulation requested for waiver is 10 NYCRR 670.1 (a-c). The projects requested for are: 3.a.i., 3.a.ii., 3.g.i. and 4.a.iii, and may be supplemented as project teams work on implementation design plans, to facilitate the addition or expansion of services and capacity to meet DSRIP goals. The reason for the waiver requested is to enable the PPS to promote rapid system reconfiguration for implementation of these projects as envisioned in the DSRIP projects submitted, to transform the delivery of services to be integrated and collaborative and expand the ability to meet patient needs in alternative locations such in primary care sites and elsewhere in the community to reduce the reliance on ED and inpatient hospital care. All of these projects require the expansion of capacity or adding or changing existing services in some respect by partners implementing the projects.

United Health Services Hospitals, Inc (PPS ID:44)

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		Projects 3.a.ii. and 4.a.iii. for e.g. are aimed to expand the ability to meet the needs of patients in a more comprehensive and collaborative manner so that medical and behavioral care needs are assessed and treated with streamlined access and by implementing collaborative methods including but not limited to IMPACT. The addition of services and capacity may be by primary care and/or behavioral health providers, as determined by whether they pursue implementation through a single provider approach or by co-locating and integrating with other licensed providers in shared space. Project 3.a.i. will require increasing or adding crisis mobilization and stabilization services and locating the provision of such services in alternate locations in the community. Project 3.g.i. will require adding palliative care services in primary care sites and this will expand the capacity of the primary care providers to care for more patients and will expand the scope of services to include palliative care through partnerships with other providers, including Hospice providers. The request for waiver is to relieve the requirements of the need for new CONs and application of assessing need methodology for determination of public need and prior review and approval and in the alternative, for DOH to determine that these elements of the required determinations, review and approval have been satisfied upon approval of the DSRIP Project application and upon PPS notice to DOH of such changes in capacity and service prior to implementation. The alternative considered by the PPS is that if prior review is going to be required to request that DOH only require limited review. We ask this as alternative relief. This waiver will not adversely impact patient safety and is not a patient safety risk because the providers involved are regulated for the provision of care and DOH will receive ample notice of the changes that will be implemented with specificity as to which providers will be collaborating and how the services will be reconfigured.
10	(Add capacity/service) 10 NYCRR 710.1 (c) (1-5,7)	The regulation requested for waiver is 10 NYCRR710.1 (c) (1-5,7). The projects requested for are: 3.a.i.; 3.a.ii.; 3.g.i. and 4.a.iii, and may be supplemented as project teams work on implementation design plans, to facilitate the addition or expansion of services and capacity to meet DSRIP goals. The reason for the waiver requested is to enable the PPS to promote rapid system reconfiguration for implementation of these projects as envisioned in the DSRIP projects submitted, to transform the delivery of services to be integrated and collaborative and expand the ability to meet patient needs in alternative locations such in primary care sites and elsewhere in the community to reduce the reliance on ED and inpatient hospital care. All of these projects require the expansion of capacity or adding or changing existing services in some respect by partners implementing the projects. Projects 3.a.ii. and 4.a.iii. for e.g. are aimed to expand the ability to meet the needs of patients in a more comprehensive and collaborative manner so that medical and behavioral care needs are assessed and treated with streamlined access and by implementing collaborative methods including but not limited to IMPACT. The addition of services and capacity may be by primary care and/or behavioral health providers, as determined by whether they pursue implementation through a single provider approach or by co-locating and integrating with other licensed providers in shared space. Project 3.a.i. will require increasing or adding crisis mobilization and stabilization services and locating the provision of such services in alternate locations in the community. Project 3.g.i. will require adding palliative care services in primary care sites and this will expand the capacity of the primary care providers to care for more patients and will expand the scope of services to include palliative care through partnerships with other

United Health Services Hospitals, Inc (PPS ID:44)

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		providers, including Hospice providers. The request for waiver is to relieve the requirements of the need for new CONs and prior review and approval and in the alternative, for DOH to determine that these elements of the required determinations, review and approval have been satisfied upon approval of the DSRIP Project application and upon PPS notice to DOH of such changes in capacity and service prior to implementation. The alternative considered by the PPS is that if prior review is going to be required to request that DOH only require limited review. We ask this as alternative relief if review will be required. This waiver will not adversely impact patient safety and is not a patient safety risk because the providers involved are regulated for the provision of care and DOH will receive ample notice of the changes that will be implemented with specificity as to which providers will be collaborating and how the services will be reconfigured. The PPS will oversee the design and implementation of these services.
11	(Relocation/Integration of Services and Home Visits by Article 28 staff) 10 NYCRR 401.2 (b)	The projects requested for are: 2.a.i.; 2.b.iv.; 3.a.i; 3.a.ii.; 3.a.i.; 3.g.i. and 4.a.iii.; and may be supplemented as project teams work on implementation design plans, to permit: (1)behavioral and/or substance use providers to operate primary care under the oversight of their regulatory agency in place of DOH and waive adherence to DOH facility standards; (2) Article 28 providers to operate primary care at additional locations within space of a different provider who is separately licensed by a state agency and(3) Article 28 staff to conduct home visits with a site of service in the patient's home. It is a priority to restructure in a way which integrates primary care, behavioral health and/or substance use services and one option is through a single provider with a single licensing agency and another is through integration and co-location of non-Article 28 medical providers or OMH-licensed behavioral and/or substance use providers with Article 28 providers. All of these projects may require changes in the location of existing services to reduce the reliance on hospital-based Emergency Departments and inpatient hospital care in some respect which may be accomplished through the relocation or addition of more locations of services by Article 28-licensed providers to off campus locations. The request for waiver is to permit approval by DOH in the form of approval of the DSRIP project application for relocation or additional locations to sites other than the currently designated site with no further CON required. Waiver will enable the PPS to promote rapid system reconfiguration for implementation of these projects as envisioned in the DSRIP projects submitted. The reason to authorize patients' homes as a site of service eligible for the provision of care and reimbursement is that in order to promote mental health services and reduce the reliance on ED and inpatient use, innovative methods of ensuring that patients receive necessary treatment will be implemented. The PPS will work with service providers and community based organizations to reduce barriers to access and this may necessitate patients being evaluated and treated in their residence. As an alternative, the PPS will consider compliance with integrated care regulations if promulgated. Alternatives for this waiver do not exist to permit home visits. Patient safety will be ensured by meeting similar standards of care when providing services as is required by the licensing agency and through PPS monitoring of quality and outcomes. Additionally, PPS-approved protocols and clinical pathways will serve as guide to ensure evidence-based and

United Health Services Hospitals, Inc (PPS ID:44)

#	Regulatory Relief(RR)	RR Response
		standardized care regardless of the oversight agency. Patient safety will be addressed in PPS-approved clinical protocols and policies to ensure patient and staff safety in determining the appropriateness and necessity of home visits to ensure that the location of services does not compromise the quality of care or safety.
12	(Changes to facility (capacity/relocation)) 10 NYCRR 710.1(c)(iv)(4)	The regulation requested for waiver is 10 NYCRR 710.1(c)(iv)(4). The projects requested for are: 3.a.i.; 3.a.ii.; 3.g.i. and 4.a.iii, and may be supplemented as project teams work on implementation design plans, to facilitate the relocation of services by waiving prior approval. All of these projects may require changes in the location of existing services to reduce the reliance on hospital-based Emergency Departments and inpatient hospital care in some respect which may be accomplished through the addition, reconfiguration, or relocation of services by Article 28-licensed providers. The request for waiver is to waive any prior review approval and permit letter notification only to DOH only with DOH approval within 15 days. The reason for the waiver requested is to enable the PPS to promote rapid system reconfiguration for implementation of these projects as envisioned in the DSRIP projects submitted. Alternatives considered by the PPS are to comply but this will result in a delay in implementation. This waiver will not adversely impact patient safety and is not a patient safety risk because the providers involved are regulated for the provision of care and DOH will receive ample notice of the changes that will be implemented with specificity as to which providers will be collaborating and how the services will be reconfigured. The PPS will oversee the design and implementation of these services and will monitor quality and outcomes to ensure the quality of services.
13	(Single license integrated care to provide medical/primary care services) 10 NYCRR 600.2	The regulation requested for waiver is 14 NYCRR 600.2. The projects requested for are: 2.a.i.; 3.a.i.; 3.g.i. and 4.a.iii.,and may be supplemented as project teams work on implementation design plans, to permit behavioral and/or substance use providers to operate primary care under the oversight of the agency regulating them (OMH, OASAS or OPWDD) without the requirement of DOH approval. One of main priorities of accomplishing DSRIP objectives is to transform the care to patients by restructuring in a way which integrates primary care, behavioral health and/or substance use services and this may be most efficiently accomplished through a single provider with single licensing agency at certain sites of service. We seek to remove or limit impediments to the provision of integrated services by licensed providers who seek to expand their scope of services. As an alternative, the PPS will consider compliance with integrated care regulations if promulgated. Patient safety will be ensured by meeting similar standards of care when providing services as is required by the licensing agency and through PPS monitoring of quality and outcomes. Additionally, PPS-approved protocols and clinical pathways will serve as guide to ensure evidence-based and standardized care regardless of the oversight agency.
14	(Collocation/Shared Space in Integrated Sites to provide medical/primary care services) 10 NYCRR 401	The regulation requested for waiver is 10 NYCRR 401.3 (d). The projects requested for are: 2.a.i.; 3.a.i.; 3.g.i. and 4.a.iii, and may be supplemented as project teams work on implementation design plans, to

United Health Services Hospitals, Inc (PPS ID:44)

#	Regulatory Relief(RR)	RR Response
		permit integration of non-Article 28 medical providers (such as physicians in private practice) or OMH-licensed behavioral and/or substance use providers within the space of an Article 28 and to authorize the Article 28 provider to lease Article 28-approved space to a provider licensed by another State agency without meeting requirements of 10 NYCRR 401.1 et seq. The reason for the request is that the focus of DSRIP is on developing integrated delivery systems, particularly addressing integration of behavioral health, substance use and medical care, and palliative care, must remove or limit impediments to the co-location of services to support implementation of DSRIP integrated care project and redirect some patients away from the ED and reduce hospital admissions through availability of primary and secondary care. One of main priorities of accomplishing DSRIP objectives is to transform the care to patients by restructuring in a way which integrates primary care, behavioral health and/or substance use services and this may be most efficiently accomplished through locating providers in shared space within certain sites of service. We seek to remove or limit impediments to the provision of integrated services by licensed providers who seek to locate their services within Article 28 space under appropriate leasing arrangements. As an alternative, the PPS will consider compliance with integrated care regulations if promulgated. Patient safety will be ensured by meeting similar standards of care when providing services as is required by the licensing agency and through PPS monitoring of quality and outcomes. Additionally, PPS-approved protocols and clinical pathways will serve as guide to ensure evidence-based and standardized care regardless of the oversight agency.
15	(Single license integrated care to provide mental health services) 14 NYCRR 599.4 (ab)	The regulation requested for waiver is 14 NYCRR 599.4 (ab). The projects requested for are: 2.a.i., 3.a.i., 3.g.i. and 4.a.iii., and may be supplemented as project teams work on implementation design plans, to permit Article 28 licensed providers to operate mental health services either within the general hospital or in an outpatient hospital department in amounts which exceed the current limits of visits annually. The 14 NYCRR 599.4 (ab) limits for volume of annual visits which may prevent a provider from qualifying for exemption, for purposes of DSRIP integrated service projects, should be increased from the current limits (10,000 and 2,000) for annual visits to eliminate an annual cap, to exempt the requirement for OMH certification in order to promote the integration of care as part of DSRIP projects. This exemption from requiring OMH licensure, regardless of the number of patients served, will help transform the method of delivering services and increase access to behavioral health and primary care. Alternatives considered include other regulatory relief such as single agency licensure. Patient safety will be ensured because Article 28 providers will comply with DOH regulations and standards.
16	(Single license integrated care-to provide mental health services) 14 NYCRR 85.4	The regulation requested for waiver is 14 NYCRR 85.4. The projects requested for are: 2.a.i; 3.a.i.; 3.g.i. and 4.a.iii., and may be supplemented as project teams work on implementation design plans, to permit DOH-regulated providers to operate mental health services under the oversight of the agency regulating them (DOH) and to forgo the

United Health Services Hospitals, Inc (PPS ID:44)

#	Regulatory Relief(RR)	RR Response
		requirements of an operating certification from OMH . One of main priorities of accomplishing DSRIP objectives is to transform the care to patients by restructuring in a way which integrates primary care, behavioral health and/or substance use services and this may be most efficiently accomplished through a single provider with single licensing agency at certain sites of service. We seek to remove or limit impediments to the provision of integrated services by licensed providers who seek to expand their scope of services to promote an integrated care model. As an alternative, the PPS will consider compliance with integrated care regulations if promulgated. Patient safety will be ensured by meeting similar standards of care when providing services as is required by the licensing agency and through PPS monitoring of quality and outcomes. Additionally, PPS-approved protocols and clinical pathways will serve as guide to ensure evidence-based and standardized care regardless of the oversight agency.
17	(Collocation in OASAS space) 14 NYCRR § 814.7	The regulation requested for waiver is 14 NYCRR 814.7. The projects requested for are: 2.a.i; 3.a.i.; 3.g.i. and 4.a.iii., and may be supplemented as project teams work on implementation design plans, to permit partner organizations who locate services in shared space with OASAS providers flexibility in the physical requirements of the space provided that the requirements of the federal regulations are adhered to. One of the main priorities of accomplishing DSRIP objectives is to transform the care to patients by restructuring in a way which integrates primary care, behavioral health with substance use. In order to collaborate and integrate, the OASAS providers need to have flexibility to collaborate with other provides in their space and treatment activities. We seek to remove or limit impediments to the provision of integrated services by licensed providers who seek to promote an integrated care model. As an alternative, the PPS will consider compliance with integrated care regulations if promulgated. Patient safety and confidentiality will be ensured by adherence to standards adopted by the integrated provides and approved by the PPS.
18	(Share Health Facility) 10 NYCRR 83.2(a)	The regulation requested for waiver is 10 NYCRR 83.2 (a). The projects requested for are: 2.a.i.; 3.a.i.; 3.g.i. and 4.a.iii., and may be supplemented as project teams work on implementation design plans, to request waiver of being considered a "Shared Health Facility" under 10 NYCRR 83.2(a) and to eliminate need for registration under 10 NYCRR 83.4 and 83.5 and compliance with any requirements of Part 83. Waiver of this regulatory definitional standard will permit integration of medical providers, behavioral and substance use providers in same settings to promote access to patient. Focus of DSRIP on developing integrated delivery systems, particularly addressing integration of behavioral health, substance use, medical care, and palliative care, so key to remove or limit impediments to the co-location of services to support implementation of DSRIP integrated care projects. The alternative is to comply with the regulations applicable to Shared Health Facilities which will cause delays in DSRIP project implementation and may increase costs.

United Health Services Hospitals, Inc (PPS ID:44)

#	Regulatory Relief(RR)	RR Response
		Patient safety is not negatively impacted by the requested waiver as the space that services will be located will comply with standards that the PPS sets in accordance with its DOH-approved project application.
19	Hospital Observation beds 10 NYCRR 405.19 (g) (2,5(b))	The regulation requested for waiver is 10 NYCRR 405.19 (g) (2,5 (b)). The projects requested for are: 2.a.i and 2.b.iv., and may be supplemented as project teams work on implementation design plans, to increase the number of hospital observations beds for the addition of observation unit beds without prior review under section 10 NYCRR 710.1(c)(2) or (3), regardless of project cost and to waive the applicable provisions of Parts 711 and 712-2 and section 712-2.4 of 10 NYCRR for construction projects approved or completed after January 1, 2011and to waive the physical space and location requirements applicable to placement of observation beds. In order to reduce the rate of hospital admission and facilitate the proper assessment and treatment of patients who may be able to be cared for in the community, or in accordance with a care transitions program, returned to a community setting following a short stay in the hospital as an outpatient, providers will need to expand capacity of observation beds and to have flexibility in the location of the beds. Alternatives to this would be to comply with the applicable regulations but this will cause delays in implementation of DSRIP project plans and will likely increase cost and may be unable to be carried out due to constraints of physical space. Patient safety will not be impacted because the care will be provided in appropriate alternative space. The PPS will monitor patient care quality to ensure that patients are cared for in accordance with appropriate standards.
20	HOME VISITSOASAS 14 NYCRR Parts 822 and 841	This request is for DOH to work with CMS through a plan amendment to move OASAS services to the rehabilitation option of the State Medicaid Plan to permit Medicaid reimbursement off site providers to provide home visits. Once OASAS is authorized, we will request waiver relevant sections in 14 NYCRR Parts 822 and 841 to request OASAS to authorize home visits for substance use treatment.
21	Source of Payment—admission and discharge 10 NYCRR 405.9 (b)(2) and (f)(7)	The regulation requested for waiver is 10 NYCRR 405.9 (b)(2) and (f)(7). The projects requested for are: 2.b.iv.; 2.b.vii.; and 3.a.ii., and may be supplemented as project teams work on implementation design plans, to permit providers when making admission decisions and when conducting discharge planning and placement of Medicaid and Uninsured to implement PPS-approved protocols for care transitions and care pathways, protocols to manage patients in appropriate settings and implement project goals to reduce ED and inpatient hospital usage. There are not alternatives to this request since the source of patient is a factor in identifying patients who may be included in certain programs. To reduce the patient safety concern, clinical governance will include competent professionals to ensure that protocols are safe and appropriate and staff will be trained to focus on patient safety and Quality. Outcomes will be closely monitored to ensure that implementation does not have an adverse impact on patient care.
22	Shared Credentialing 10 NYCRR Part 405; specifically 405.2(e)(3) and §405.4(c)(5)	The regulations requested for waiver are: 10 NYCRR Part 405; specifically405.2(e)(3) and §405.4(c)(5). The projects requested for are: 2.a.i.; 2.b.iv.; 2.b.vii.; 2.c.i.; 2.d.i.; 3.a.i; 3.a.ii.; 3.b.i.; 3.g.i.; 4.a.ii. and 4.b.iii. to streamline the credentialing process within the PPS to create a system-wide process which will facilitate the rapid integration of services required to provide coordinated care by providers participating in PPS. In particular, the waiver would allow PPS to

United Health Services Hospitals, Inc (PPS ID:44)

#	Regulatory Relief(RR)	RR Response
		establish a shared credentialing process and standards to: (i) conduct primary source verification; (ii) screen for Medicare and Medicaid exclusion; (iii) and assure consistent standards to promote quality and patient safety, relying on data available to partner organizations and to the PPS through its own monitoring and data collection. The waiver would reduce the cost and administrative burden of credentialing by each partner organization, and would allow health care professionals to practice in different settings as needed for care coordination without duplicative credentialing by numerous providers throughout the PPS. The waiver is also requested to permit certain practices that may be necessary to implement coordinated care models, such as allowing a physician in private practice to supervise more than two physicians' assistants (10 NYCRR 94.2). The only alternative would be to continue the existing process for credentialing which as noted above will be highly demanding and labor and cost intensive, and will not provide the same degree of oversight or operational coordination based on a single set of credentialing standards and criteria. PPS will use development of a single set of credentialing standards, criteria, and centralized review process to improve patient safety by assuring that consistent, sound standards are adopted and uniformly applied for health care professionals across partner organizations. Centralized credentialing would still entail collecting and relying upon information from each partner organization about health care professionals practicing under their license and supervision, but would also allow for a more objective evaluation by professionals who are not peers of individual practitioners. Moreover, PPS will be able to use its own quality data and observations based on project participation to inform the review process.
23	SNF behavioral health care 10 NYCRR Part 415.39(a-e)	This request is to waive regulations encompassed by 10 NYCRR Part 415.39(a-e) that govern the provision of behavioral health services by skilled nursing facilities (SNFs). The projects requested for are: 2.a.i.; 2.b.iv.; 2.b.vii.; 3.a.ii.; and 4.a.iii, and may be supplemented as project teams work on implementation design plans, to authorize the provision of expanded behavioral health services, as appropriate, at skilled nursing facilities to reduce preventable hospital use in the emergency room and preventable hospital admissions. The waiver is requested to allow SNFs to admit a higher number of patients with behavioral health conditions, and care for them with access to the necessary expertise and physician supervision through telemedicine and increased affiliations with partner organizations, in accordance with the policies and procedures adopted by the SNFs and the PPS to assure patient safety of both the residents treated and other residents in the facilities. Specifically, PPS is seeking to waive the requirements to: (i) establish or operate an independent unit to treat patients for behavioral health conditions (10 NYCRR 415.39(a)(3); and (ii) allow flexibility to permit therapeutic interventions in the SNFs and provide access to health care professionals from partner organizations in the PPS to expand the availability of expertise and treatment to better manage and care for patients with behavioral health needs in SNFs. The alternatives to the waiver would not be feasible. It would require establishment of discrete units for behavioral health residents would significantly increase the capital costs for treating residents with significant mental health conditions in SNFs, and would make the addition of these

United Health Services Hospitals, Inc (PPS ID:44)

#	Regulatory Relief(RR)	RR Response
		services infeasible in some, if not many, SNFs. Telemedicine will greatly expand access to mental health professionals in SNFs both in general, and at particular times when such expertise is not available onsite at SNFs. In consultation with SNFs participating in PPS projects that require this waiver, PPS will develop practice guidelines and clinical protocols to address patient safety and protect the interests of both the residents with behavioral health problems as well other residents. As part of project implementation, PPS will oversee and monitor implementation of the protocols in SNFs that care for residents with behavioral health conditions treated in a unit shared with other residents.
24	Home Care Orders 10 NYCRR §766.4	This request seeks a waiver of 10 NYCRR §766.4 to allow physician assistants to sign medical orders for home care services provided by licensed home care services agencies (LHCSAs). The projects requested for are: 2.a.i.; 2.b.iv.; 3.a.ii.; 3.b.i.;and 4.b.ii., and may be supplemented as project teams work on implementation design plans, to authorize Physician Assistants (PAs)to issue home care orders and be deemed "authorized practitioners" under 10 NYCRR §763.7. There is no alternative that would extend the availability of medical orders and timely access to treatment as effectively as this change for patients cared for by LHCSAs in the community. This will not adversely impact patient safety. The waiver will improve timely access to services to patients cared for in the community by LHCSAs. Development of the PPS and affiliations created for DSRIP project purposes will expand the pool of physicians available for consultation as needed by PAs in carrying out this expanded responsibility. In consultation with LHCSAs and physicians, PPS will develop protocols specifying the medical orders that PAs can sign and address limitations for such authority to assure that the waiver does not have an impact on patient safety. In addition to the specific waiver request above, PPS requests that the Department of Health and Department of Education pursue a legislative proposal to allow non-patient specific nurse-driven protocols by amending the Nurse Practice Act and regulations in Title 8. Additionally, pursue legislative changes to permit home health aides with appropriate training to administer medications in home care and hospice settings, and provide other advanced interventions that are deemed safe and appropriate by the regulators. This would also facilitate system clinical integration and the projects that seek to provide timely preventive and daily care to patients in their homes or other community settings.
25	Assessments of long term care patients 10 NYCRR §400.11(a)	This request is to waive 10 NYCRR §400.11(a), to permit staff who do not satisfy the credentials set forth in the regulations to conduct an assessment necessary for initial or continued placement in a nursing home to perform the assessments. The projects requested for are: 2.a.i.; 2.b.iv.; 2.b.vii.; 3.a.i.; and 3.a.ii., and may be supplemented as project teams work on implementation design plans, to facilitate the transfer of residents from hospitals to nursing homes by allowing health care professionals with a broader range of credentials than those identified in the regulations to conduct the assessment of potential residents prior to their initial or continued placement in long-term care facilities. The alternative would be a further costly investment in staff that may not align with hospitals' and nursing homes' other staffing needs. The waiver would avoid delays in transferring patients to nursing homes and allow

United Health Services Hospitals, Inc (PPS ID:44)

#	Regulatory Relief(RR)	RR Response
		transfer in a timeframe that aligns with the patient's clinical needs and condition. In consultation with partner organization nursing homes and hospitals, PPS will develop a protocol that identifies the clinical credentials and training required for individuals who fill out the assessment for initial or continued placement at a long-term care facility to assure that the assessment is complete and accurate, and does not affect patient safety.
26	Assessments of long term care patients 10 NYCRR §700.3(a)(1-2)	This request is to waive 10 NYCRR §700.3(a)(1-2) to permit staff who do not satisfy the credentials set forth in the regulations to conduct an assessment necessary for initial or continued placement in a nursing home to perform the assessments. The projects requested for are: 2.a.i; 2.b.iv; 2.b.vii; 3.a.i; and 3.a.ii, and may be supplemented as project teams work on implementation design plans, to facilitate the transfer of residents from hospitals to nursing homes by allowing health care professionals with a broader range of credentials than those identified in the regulations to conduct the assessment of potential residents prior to their initial or continued placement in long-term care facilities. The alternative would be a further costly investment in staff that may not align with hospitals' and nursing homes' other staffing needs. The waiver would avoid delays in transferring patients to nursing homes and allow transfer in a timeframe that aligns with the patient's clinical needs and condition. In consultation with partner organization nursing homes and hospitals, PPS will develop a protocol that identifies the clinical credentials and training required for individuals who fill out the assessment for initial or continued placement at a long-term care facility to assure that the assessment is complete and accurate, and does not affect patient safety.
27	Home Visits-OMH 14 NYCRR 679.5	This request is to waive 14 NYCRR 679.5. The projects requested for are: 2.a.i.;2.b.iv.; 3.a.i.; 3.a.ii. and 4.a.iii, and may be supplemented as project teams work on implementation design plans, to permit to permit clinic treatment staff to conduct home visits and be eligible for reimbursement with a site of service in the patient's home. The reason for this request is that in order to promote mental health services and reduce the reliance on ED and inpatient use, innovative methods of ensuring that patients receive necessary treatment will be implemented. The PPS will work with service providers and community based organizations to reduce barriers to access and this may necessitate patients being evaluated and treated in their residence. Alternatives for this waiver do not exist to permit home visits. Patient safety will be addressed in PPS-approved clinical protocols and policies to ensure patient and staff safety in determining the appropriateness and necessity of home visits to ensure that the location of services does not compromise the quality of care or safety.

United Health Services Hospitals, Inc (PPS ID:44)

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 Southern Tier Rural Integrated PPS (STRIPPS) plans to operate using the Delegated Governance model. STRIPPS will be formed as a non-charitable not-for-profit New York Corporation and will seek to qualify as 501 (c)(6). This structure was considered the best fit model because it is simple in its design and fosters the strategic and operational communication and collaboration needed to transform service delivery in the nine county STRIPPS service area. STRIPPS has shaped the model to achieve balanced representation and integration of providers and resources currently involved in the delivery of care to Medicaid beneficiaries and the uninsured. The delegated model structure accommodates the use of capital contributing partners who may be called upon to financially bridge the PPS when fluctuations occur in cash in-flows. This governance model, in combination with the Project Advisory Committee (PAC) and the STRIPPS operational organization, allows for efficient information exchange and decision making in the operation of the PPS.

In addition, please attach a copy of the organizational chart of the PPS. Please reference the "Governance How to Guide" prepared by the

United Health Services Hospitals, Inc (PPS ID:44)

DSRIP Support Team for helpful guidance on governance structural options the PPS should consider.

File Upload: (PDF or Microsoft Office only)

Currently Uploaded File: **(none)**

Description of File

File Uploaded By:

File Uploaded On:

***Structure 2:**

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

The governance and operational processes were designed around the primary business purposes of the PPS, specifically: maintenance of the safety network, implementation of the projects, performance assessment monitoring and management, management of funds flow, development of financial capacity, and oversight of PPS operations as they evolve. The key elements include: an eleven member executive governance body or Board, a 25 member PAC executive body representing a 150 member PAC; three organized PPS domains to support decision-making related to Finance, Information Technology (IT) /Data Governance and Clinical Performance; a Corporate Compliance and Audit Committee; and three Regional Performance Units (RPUs) where performance management is operationalized. The Board is comprised of five distinct healthcare system members, one FQHC member and five community based organization (CBO) members. There will be six capital contributing partners forming the corporate member of the Board. Corporate members include: Cayuga Health System, Inc.; Cortland Regional Medical Center, Inc.; Family Health Network of Central New York, Inc.; The Guthrie Clinic, Inc.; Our Lady of Lourdes Health Memorial Hospital, Inc. and United Health Services, Inc. The corporate member holds reserve powers typically reserved to not-for profit members such as the right to approve amendments to the charter documents and significant transactions as well as DSRIP specific powers such as the right to approve modifications to the approved DSRIP Plan Collectively, the full Board is responsible for monitoring the performance of STRIPS in all three domains to achieve the DSRIP goals, creating and sustaining an integrated high performing health care delivery system and taking into due consideration the recommendations of the Project Advisory Committee (PAC). The Board is supported in this effort by four working committees: The Clinical Governance Committee, responsible for establishing clinical standards, monitoring performance and reporting; The IT and Data Governance Committee responsible for the development of the required data sharing and exchange infrastructure to support coordinated care delivery; the Finance Committee, responsible for the management and distribution of funds in accordance with performance standards and operational policies of the PPS, and; the Compliance and Audit Committee responsible for the development and implementation of the STRIPPS Corporate Compliance Plan and the work of the independent Corporate Compliance Officer. This committee will also annually retain and oversee the conduct of the external audit. The members for staffing the Finance, Clinical and IT/Data Governance committees will be selected from the work teams supporting the development of the DSRIP Application. Formation of the committees will be consistent with the STRIPPS bylaws, and be implemented by April 1, 2015. The STRIPPS operational structure is rooted in three Regional Performance Units (RPUs) where key interventions and programs designed to manage the Medicaid beneficiary population and the uninsured to improved outcomes will be implemented and monitored. The PPS operating structure which includes, Project Management, IT support, provider relations, workforce transition fund management, population health analytics and outreach services, provide an efficient and centralized infrastructure to support RPUs. The STRIPPS operating structure is led by an executive director who is a nonvoting member of the Board. The design and interaction of the governance and organizational elements provides a solid framework for the communication, collaboration, compliance monitoring and decision-making needed for the delivery system transformation envisioned by DSRIP.

***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 central organizational element to ensure clinical governance in STRIPPS is the Clinical Governance Committee. This committee is comprised of up to ten members from Partner Organizations with expertise in quality measurement, improvement and reporting, care coordination and population health. The committee will also have members with expertise in differing professional disciplines and care settings to provide effective oversight of PPS care delivery, the establishment of quality standards and the assessment of PPS–wide quality performance and DSRIP project performance. These responsibilities specifically include: making recommendations regarding

United Health Services Hospitals, Inc (PPS ID:44)

standardized care management processes and evidenced based pathways; utilizing uniform and validated metrics for reporting; reviewing and reporting performance data including data and recommendations generated by rapid cycle evaluation; and participation in value based payment oversight. The effectiveness of Clinical Governance relies on a focused work flow from STRIPPS operations which connects day-to-day clinical activity to overall PPS performance and accountability. To support Clinical Governance, STRIPPS operations is organized into four divisions: Project Management; Operations, including provider relations, workforce strategy implementation support and fund management; Population Health which includes advanced analytics to risk stratify, track, monitor and report performance, identify performance improvement opportunities, and; Communications and Outreach whose focus is beneficiary engagement. STRIPPS Operations works directly with three Regional Performance Units (RPUs) that are organized within naturally occurring geographic areas of care delivery in STRIPPS. This structure provides a direct connection from local care delivery, through PPS operations to Clinical Governance that ensures the ability to standardize, monitor and be accountable for performance from care delivery through the governance level.

***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.

Over the five year period of the DSRIP program, STRIPPS must evolve from being paid to transform the focus and structural elements of care delivery to Medicaid beneficiaries and the uninsured to being paid for the consistent delivery of targeted, population based outcomes. STRIPPS organizational structure is well suited to successfully oversee this transition because it assures inclusion of partner providers through the PAC. The eleven member board is sized for efficient decision-making, allowing the board to focus on delivery system transformation as well as the ongoing performance of the PPS. Yet the board is also representative of the participating providers and the geographic region they serve. The board will include corporate member representation to provide a stable foundation, but also has broad representation through PAC nominated board members from the PAC Executive Committee (PACEC). The PACEC assures active engagement and provides a forum to groom partner representatives for positions on the STRIPPS Board. Additional provider representatives will be active on Board committees and in the Regional Performance Units (RPUs). This inclusive organizational structure will foster the strategic and operational communication required for STRIPPS and its participating providers to successfully collaborate and adapt together, over time, becoming a highly performing organization.

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.

STRIPPS has an 11 person Board with one corporate member comprised of executive leadership representation from each of the five health system partners and the FQHC. These partners are capital contributing partners and as such hold legally appropriate reserve powers. The names of five of the individuals in these board positions are: Matthew Salanger, President and CEO of UHS, John Rudd, President and CEO of Cayuga Medical Center, Mark Webster, President and CEO of Cortland Regional Medical Center, Joseph Scopeletti M.D. President and CEO of Guthrie, Walt Priest President and CEO of the Family Health Network and Kathy Connerton, President and CEO of Our Lady of Lords Hospital. The remaining five Board seats will be filled from a slate of community based organization (CBO) representatives. To promote shared governance among the partner organizations, this slate will be developed and by the nominating committee of the Project Advisory Committee Executive Committee (PAC EC), with attention to achieving a balance of representation across CBO care sectors in STRIPPS. The board members are collectively charged with the general oversight of the affairs, assets and business of STRIPPS.

***Process 2:**

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

During the application development process, STRIPPS formed an eleven member governance team to design the governance model and develop the processes for forming the governing body or Board. The team used guidance provided by the DSRIP Support Team and legal counsel as the basis for its recommendations. This work of this team was progressively reviewed and endorsed at every PAC meeting held between October 1, 2014 and the filing of the application. When the decision was made to have a corporate member comprised of

United Health Services Hospitals, Inc (PPS ID:44)

capital contributing partner organizations, it followed that each partner organization, who was a corporate member, would have the authority to appoint their representative to a governing body seat. It was agreed that given the importance of DSRIP, the appointee would be the President and CEO of the capital contributing partner organization or a designee of the President and CEO who would have full authority to act. The remaining five seats of the governing body are Community Based Organization (CBO) seats which will be filled by a process conducted through the Project Advisory Committee (PAC). Given the large size of the STRIPPS PAC, the PAC elected to have a 25 member Executive Committee comprised of individuals who collectively represented the service area and all service sectors in the PPS. A slate to establish the PAC Executive Committee (PAC EC) was developed by subset of PAC members and presented to the PAC for input and consideration at its October 24, 2014 meeting and subsequently ratified by the PAC at its November 7, 2014 meeting. The PAC EC is in the process of electing a chair and appointing a nominating committee. The nominating committee will establish the qualifications of Board candidates and the CBO candidate slate and will identify a slate of individuals to fill the five CBO governing body seats. This slate will be reviewed and ratified by the full PAC. The slate will then be recommended to the corporate member who appoints the slate to the Board seats.

***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.

They key to effective representativeness, lies in the governing body design and the hard wired communication forums that support governance, specifically the PAC and the PAC Executive Committee PAC EC). The PAC is inclusive of all stakeholders and partners from a broad range of Community Based Organizations (CBOs). It is the successful engagement of the PAC that secures the representativeness of diverse perspectives in key decisions related to STRIPPS. The operating approach that STRIPPS has used in the development of the application has achieved high levels of PAC engagement with over 80 member organizations consistently attending PAC meetings and actively participating in dialog around key decisions. Maintaining that engagement will yield informed and knowledgeable candidates for board seats who have an understanding of the vision for STRIPPS and will bring their perspective, as well as the perspective of others, into the governance process.

***Process 4:**

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

CBO Coalition partners are members of the PAC and have active involvement throughout the STRIPPS organizational Community based organizations (CBOs) will be involved in (i) STRIPPS' Regional Performance Units, where performance management is operationalized, (ii) Board Committees, where the varied expertise of the CBO representatives will help drive committee performance, and (iii) the Board of Directors, with five Board seats to be filled with PAC nominated individuals. Accordingly, CBO coalition partners will be well represented throughout the organizational structure. CBO contracting will be structured based on performance targets with performance review occurring through the RPUs and Clinical performance Committee

***Process 5:**

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

The governing body for STRIPPS is comprised of an 11 member board, with a corporate member comprised of six capital contributing partner organizations. The corporate members have reserve powers related to designation of members, disposition of assets, dissolution, approval of mergers, consolidations and affiliations, settlement of litigation, and approval of the DSRIP Project plan. Decisions subject to reserve powers require a two-thirds majority vote for approval. For decisions not subject to the reserve powers, a two-thirds majority vote of the eleven member Board is required. A similar simple majority voting structure is used in the PAC and the PAC Executive Committee. At the domain and operational levels of the organization, the guiding principal for decision-making will be consensus among team members related to reports and recommendations that move up into the PAC and the Board. In the event of any unresolved matter, a full disclosure of the differing views would be escalated to the board for resolution consistent with the dispute resolution policy.

***Process 6:**

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

The overall culture developed in STRIPPS has been one of education and consensus building. In the event of disagreement, several structural elements have been built in to help the PPS move through conflict. At the board level, the ability to act relies on simple majority to avoid deadlock on decisions. At committee and operational levels, when there are material differences related to reporting and

United Health Services Hospitals, Inc (PPS ID:44)

recommendations, a full description and disclosure of the differing views would be escalated to the PAC and Governing Board for resolution.

***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.

Since the beginning of STRIPPS, a web-based Sharepoint site has been in place. All members of STRIPPS are given password protected access to the site. All committee agendas, meeting minutes and a Master Calendar are organized and posted to the site. Meeting minutes are also distributed through traditional methods. When the Board of Directors and Committees are implemented, notices of meetings, proposed agendas and minutes will be posted. In addition, it has been the operating style of STRIPPS to share agendas and pending actions from the Governance Design team at all PAC meetings to assure high levels of awareness and feedback around key structural and formative decisions. This approach will continue with the implementation of the formal governance structure. Additionally, the information regarding agendas and meeting output will be built into the operational committee meetings and staff meetings to assure broad communication and understanding around governance activity.

***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.

In its formation, STRIPPS has successfully secured a high level of sustained engagement among partners and stakeholders. The methods used to achieve this level of engagement have been based on consistent communication, frequent meetings (in-person and supported by Webex) with planned agendas, open dialog, and inclusion. When working with complex issues, multiple communications and meetings have been planned with presentations and discussions to assure understanding and to incorporate feedback. When the governing structure is implemented, stakeholders will continue to be actively engaged on key and critical topics through all forums including active participation on the Board of Directors, Board Committees, The Regional Performance Units, and in the PAC and PAC EC. Each of these bodies will continue to build on the above described methods, meeting regularly and posting notices of meetings, proposed agendas and minutes on the Sharepoint site.

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 formation of the PAC dates back to the development of the Planning Design Grant (PDG) in April of 2014. At that time, what is now STRIPPS was two separate PPSs, the Southern Tier PPS(STPPS) and the Rural Integrated PPS (RIPPS). Each PPS immediately formed a PAC and met with the PAC throughout the PDG development process. With the award of the PDG funds, DOH recommended to STPPS that consideration be given to engaging in a dialog with RIPPS around integrating the two PPSs. Over a four week period the leadership of each PPS along with each PAC entered into discussion around the efficacy of combining the two organizations. Each PAC had a critical voice in that decision. Though those discussions it was determined that combining into a single PPS would best serve the needs of the regional population. Once the integration occurred in the final weeks of September 2014, STRIPPS was formed and an integrated PAC began to meet. The overall PAC has over 130 organization members spanning the nine county service area and across all sectors care delivery. In accordance with DSRIP requirements, PAC members are comprised of management and workforce representatives from participating organizations. Since the integration ten weeks ago, there have been eight PAC meetings. Key topics for the PAC have included the Community Needs Assessment, design of key functionality of the PPS, formalizing the PAC structure with an Executive Committee and organizational pathways to connect with the formal governing body of STRIPPS.

***Committee 2:**

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

The PAC is organized to provide ongoing input and advise to the Board of Directors. Due to its size, the PAC is organized with a 25 member Executive Committee to assure proper function, including monitoring, convening, reporting and recommending. The PAC

United Health Services Hospitals, Inc (PPS ID:44)

nominating committee will establish the qualifications of candidates to constitute a slate of individuals from community based partner organizations to fill five seats on the Board of Directors. PAC representatives will also serve on board committees and in the Regional Performance Units as well. While formal meeting schedules have not been developed as yet, the PAC and PAC EC will meet routinely throughout the lifecycle of the PPS. The PAC and PAC EC are essential communication venues for advisement and input on operational policies, performance reporting, communication with stakeholders and beneficiaries, grooming of STRIPPS board talent and the election of Community Based Organization (CBO) Board members.

***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 design of the PPS organizational structure, the implementation of the Community Needs Assessment (CNA), the incorporation of CNA findings in the selection and design of the STRIPPS projects and the overall functionality of the PPS have been the central topics of PAC meetings since October 2014. Members of the PAC have played critical roles in the conduct of the CNA, facilitating interviews, data collection, and directly participating in surveys and focus groups. In addition, PAC members provided critical insight into some of the CNA findings. The development of the governance structure and operating structure was tasked to a PPS work group. Output from that group and the proposed models were vetted and discussed with the PAC across several PAC meetings.

***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.

STRIPPS has a PAC that includes all the partners and community organizations in the network. Therefore, by design, it is representative of the PPS network. PAC meetings have been consistently well attended and members have been engaged and participating since the PAC came together.

Section 2.4 – Compliance:

Description:

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

***Compliance 1:**

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

The Audit/Compliance Committee of the Board of Directors will be charged with the identification of an appropriate compliance official for STRIPPS with extensive experience in health care compliance. The Compliance Official will be accountable to the Executive Director and the Board of Directors, working closely with compliance officers at partner organizations to leverage their programs, knowledge and existing strength in the development of the STRIPPS compliance program and plan. The Compliance Official will be responsible for the development and implementation of the STRIPPS Compliance Plan, including the hotline, compliance training, audit schedules and priorities, and will report at each Compliance and Audit Committee and each governing board meeting, recommending action on all compliance matters brought to the attention of the Board.

***Compliance 2:**

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

STRIPPS will implement a comprehensive compliance program that contains the required elements set forth in Social Services Law 363-d to prevent, detect, and address compliance matters relating to STRIPP's operations, projects and performance. The Compliance Official will report to the STRIPPS Audit/ Compliance Committee which will oversee the compliance program, approve the annual compliance plan, review audit findings and matters brought to its attention and oversee resolution. All contracts, policies and procedures that could raise compliance concerns will be reviewed by the Compliance Official prior to implementation. STRIPPS will establish and publicize a Code of Conduct and implement a hotline for anonymous and confidential compliance reporting. STRIPPS staff and partner organizations will be required to report potential violations arising from PPS operations and performance to the STRIPPS Compliance Official and assist in investigating and resolving issues. STRIPPS will have a policy to sanction staff and participants for failure to report and for compliance

United Health Services Hospitals, Inc (PPS ID:44)

violations determined to contribute to poor performance.

***Compliance 3:**

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

STRIPPS will develop and implement compliance training for PPS leadership, staff and partnering organizations and employees that at a minimum covers: STRIPPS Code of Conduct and policies, STRIPPS HIPAA program, anti-trust requirements the STRIPPS hotline, fraud and abuse laws relaxant to STRIPPS operations and performance and non-retaliation and non-intimidation policies. STRIPPS will develop a planning consultation with partner organizations to coordinate STRIPPS compliance training with ongoing compliance training by partner organizations.

***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.

For all target populations of the PPS, achieving overall performance success directly depends on engagement and activation. To engage Medicaid beneficiaries and the uninsured individuals targeted in the 11th project, STRIPPS must locate individuals, meet with them and secure their consent to share their data with STRIPPS providers for effective care coordination and management. The optimal time to start communication about how to file a compliance complaint will be at that time. Additional access to information about filing e a compliance complaint will also be available on the public website, on the websites of partner organizations, and in printed materials. STRIPPS will establish a website link and hotline for compliance complaints, including confidential and anonymous reporting and inform provider and community based partner organizations and beneficiaries of these options.

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 achieve financial success, STRIPPS requires processes to: flexibly manage and distribute funds during all phases of DSRIP; to monitor project costs and achievement of milestones; integrate quality and finance data to support performance based payments; distribute incentive payments with down to the individual provider level, and; track the financial stability of the provider safety net. Day to day management of these processes are organized in the STRIPPS Operations Division, with staff who collect and organize the flow of financial and performance data, to create reports and dashboards that assist in the management of funds flow in the PPS. The staff will be responsive to the direction of the STRIPPS Finance Committee, who will review and redirect processes as necessary to achieve financial targets. The STRIPPS Finance Committee, comprised of members from Partner Organizations who have expertise in management and finance, will receive and review all matters related to the fiscal operation of STRIPPS, and will provide synthesized information to the Board to support financial decision-making and policy development for the PPS.

***Organization 2:**

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

STRIPPS will have five key financial functions: Accounting functions, to produce financial statements on a regular basis, manage distribution of funds in a manner that conforms with budget allocation percentages, supporting the management of the cash flow of funds matching inflows from DOH against outflows for projects, revenue loss and administration; Budget Function to assist project implementation teams with the tracking of project costs against budgeted amounts, and where needed, re-distribute of funds; Financial Analysis, to build and populate dashboards with relevant financial metrics, perform analysis to support fund distribution, perform ad hoc analysis related financial performance including revenue loss analysis to monitor the financial stability of safety net providers; Contract Services, to coordinate discussions and negotiations with Medicaid MCOs on behalf of STRIPPS; oversight of the fiscal sustainability of STRIPPS, and; Capital Asset Management to track and manage capital funds and monitor STRIPPS capital investments.

United Health Services Hospitals, Inc (PPS ID:44)

***Organization 3:**

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

UHS Hospitals, Inc. serves as the Lead for STRIPPS and in that capacity serves as custodian of all STRIPPS funding. UHSH, Inc. undergoes an annual external independent audit which is overseen by the Audit Committee of UHSH, Inc. STRIPPS is organizing using the Delegated model of governance which calls for the formation of new company. The bylaws of STRIPPS provide for a Compliance/Audit Committee which, as described more fully in the Compliance section of this Section 2 of the application, provides for overseeing of the internal control environment and an independent external financial audit of STRIPPS. The annual independent audit report will be made available to all member organizations comprising STRIPPS. The Compliance/Audit Committee will review all recommendations related to strengthening the internal control environment. The Compliance/Audit Committee may authorize focused internal audits from time to time. In those circumstances it is the intent of STRIPPS to leverage internal audit capabilities from member organizations.

***Organization 4:**

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

STRIPPS will develop and implement an effective compliance program, inclusive of financial compliance conforming to Social Services Law 363-d to prevent, detect, and address compliance matters relating to PPS operations and Projects. The PPS will charter this work through a work group comprised of representatives from the Finance and Audit/Compliance Committees.

Section 2.6 – Oversight:

Description:

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

***Oversight 1:**

Describe the process in which the PPS will monitor performance.

Performance oversight is based on milestone achievement, reductions in avoidable admissions and emergency room visits and achievement of specific metrics associated with DSRIP projects. Performance monitoring begins in operations with The Population Health and Financial Analysis functions. Utilizing claims-based data and locally developed clinical data, routine reports and dashboards are used to track metrics and targets. Population Health also performs data mining and customized process improvement studies to reveal additional opportunities for performance improvement. This performance data is utilized by the Regional Performance Units (RPU) to monitor local performance and develop tailored interventions and action plans to achieve performance targets. The performance data and RPUs' actions plans are aggregated by Population Health analysts and the resulting reports are reviewed by the Clinical Performance Committee. The Clinical Performance Committee provides oversight and feedback to the RPUs and reports and recommends actions and policies to the Board.

***Oversight 2:**

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

Lower performing members will be identified in the performance monitoring process. The Clinical Performance Committee will refer concerns about specific issues to the RPU's for direct follow-up with the member identified. The follow-up will consist of data sharing and dialog to uncover the issues impacting performance. As a result of the follow-up, a plan of correction will be developed and submitted by the low performing member, and approved by the Clinical Performance Committee. The plan will include specific interventions with target dates which will be monitored in the RPU and Reported to the Clinical Performance Committee. Failure to meet Plan of Correction milestones or improve performance will be reviewed and referred to the Clinical Performance Committee for further action, up to and including dismissal from the PPS network.

***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.

Poor performers who progress through corrective action planning as noted in Oversight 2, and who fail to improve consistent with the plan of correction they developed, will be referred to the Clinical Performance Committee. Within two weeks of the referral, The Clinical

United Health Services Hospitals, Inc (PPS ID:44)

Performance Committee will convene a Performance Review Panel who will hold a closed session review of the issues with the poor performer. Based on the results of the Review Panel discussion and deliberation, a recommendation will be made to the Board regarding conditions for continuation in the network, including economic sanction. Depending on the nature of the performance issue, a recommendation for dismissal from the network could be made.

***Oversight 4:**

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

Many of the providers in the STRIPPS network have well organized mechanisms for garnering beneficiary feedback through patient experience surveys. STRIPPs can leverage those efforts to gain qualitative and quantitative feedback about providers. In addition, STRIPPs will establish and promote feedback opportunities through the STRIPPS public website. For those beneficiaries engaged in care coordination, a feedback mechanism will be incorporated into care plan update process.

***Oversight 5:**

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

In the event that a provider is removed from the network, the participating provider list on the STRIPPS website will be updated. In addition, beneficiaries and their care coordinators will be sent a letter informing them of the change in their provider's participation status. The letter will offer alternative participating providers. Letters or notices will be made available at the transitioning provider's location. STRIPPS leadership understands that change of provide can be a very disruptive event for the beneficiary. Follow-up from their assigned care coordinator will include telephonic contact and facilitation with provider transition when possible.

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

United Health Services Hospitals, Inc (PPS ID:44)

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

United Health Services Hospitals, Inc (PPS ID:44)

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 CNA was developed in accordance with Guidance for Conducting Community Needs Assessments documents provided by NYSDOH and the checklist provided by the DSRIP support team. The CNA validates the 11 projects selected will transform the current healthcare delivery system resulting in achievement of the DSRIP goals.
STRIPPS conducted a multi-faceted CNA utilizing a three-pronged approach: a meta-analysis of the existing 2013-2017 organizational health needs assessments; extensive qualitative research study of providers, community organizations, MCD/UI beneficiaries within the Region; and new quantitative research utilizing the Salient data chartbooks.
In the meta-analysis, County DOH and hospital CHNA/CHIPS, DSS Mental Health Hygiene Assessments, and NYSDOH data were reviewed for commonalities and county specific health needs.
Qualitative research involved health providers; community leaders, organizations, and residents; Medicaid beneficiaries and individuals without insurance. Across the Region, 2011 on-line surveys were completed (57.7% by community residents; 32% of the community residents or 375 were MCD/UI), 90 In-depth Individual Interviews ("IDI"-38 with healthcare providers, 52 community agency associates). 15 focus groups comprised of 127 MCD/UI participants were conducted. IDI participants were selected based on community or health expertise, or to represent particular issues (substance abuse, homelessness, transportation, etc). Focus groups were conducted across the Region to elicit input on county specific resources and challenges. The number of focus groups and IDI were based on geographic density of MCD/UI. Project interventions and transformative principles were tested for potential impact with focus groups.
New qualitative research utilized data obtained from the DSRIP chartbooks to create a guideline for scale of opportunity though an analysis of the maximum avoidable admissions, by category, and unnecessary ED visits.

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

Data analysis followed the recommendations and guidelines set forth in the Guidance document, and hi-lighted challenges for the Region MCD/UI, with an emphasis on the care delivery system, the influence of the care delivery system on identified community health status, avoidable hospitalizations, re-hospitalizations, and unnecessary emergency room visits.
Numerous data sources were leveraged in this process. The meta-analysis reviewed publically available information on the health care and community resources, disease prevalence, demographic characteristics, quality metrics, and social determinants of health utilizing the NYS Community Health Indicator Reports, Behavior Risk Factor Surveillance Systems, Medicaid Managed Care Reports, Statewide Planning and Research Cooperative dataset, PQI and HCAHPS information, and community health surveys, reports and studies.
Secondary data sources available through a Provider and Community Resource study identified the PPS capacity to implement the selected projects. Data was additionally obtained from the DSRIP chartbooks, workbooks, and dashboards for the Region.
Extensive primary research of health and health-related providers, community-based organizations, and community members including MCD/UI used multiple analytic modalities including, sample surveying, focused group interviewing, and individual interviews. The

United Health Services Hospitals, Inc (PPS ID:44)

responses were synthesized through categorical response analysis techniques which hi-lited relevant themes and associations. Top 4 themes identified were opportunities to 1) improve MCD preventable hospitalizations for cardiovascular diseases, chronic disease (diabetes, asthma, COPD) and mental health. 2) Increase access to mental health and substance abuse services (top priority). 3) improve access to transportation for non-ED services.4)increase awareness of healthcare services beyond the ED. All analytic findings support the selection of the 11 projects.

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	23	12
2	Ambulatory surgical centers	11	9
3	Urgent care centers	9	7
4	Health Homes	2	2
5	Federally qualified health centers	0	0
6	Primary care providers including private, clinics, hospital based including residency programs	584	301
7	Specialty medical providers including private, clinics, hospital based including residency programs	662	584
8	Dental providers including public and private	316	2
9	Rehabilitative services including physical therapy, occupational therapy, and speech therapy, inpatient and community based	44	19
10	Behavioral health resources (including future 1915i providers)	88	67
11	Specialty medical programs such as eating disorders program, autism spectrum early	0	0
12	diagnosis/early intervention	28	13
13	Skilled nursing homes, assisted living facilities	37	22
14	Home care services	71	15
15	Laboratory and radiology services including home care and community access	25	13
16	Specialty developmental disability services	25	13
17	Specialty services providers such as vision care and DME	63	11
18	Pharmacies	5	1
19	Local Health Departments	9	9
20	Managed care organizations	9	0
21	Foster Children Agencies	32	6
22	Area Health Education Centers (AHECs)	4	0
23	Hospice	5	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.

United Health Services Hospitals, Inc (PPS ID:44)

There are 23 hospitals providing acute care services across the Region, 9 of which are apart of STRIPPS. These hospitals include 2 critical access facilities, 1 sole community provider with 162 beds, and the remaining facilities with bed capacity ranging from 65–280 beds. Of these hospitals, the UHS and Lourdes Systems located in Broome County treat the largest proportions of MCD/UI given the population density located within their geographic area. STRIPPS proposes restructuring its bed capacity to allow for more acute patients and reduce the number of double occupancy rooms.
Approximately 50% of the providers within STRIPPS have attained PCMH-certification; roughly half of those have achieved the 2014 Level 3 PCMH certification. The remaining providers currently lack the communication infrastructure necessary to engage in care coordination to provide improved evidence-based care to STRIPPS MCD beneficiaries. There are 4 MCD health homes in the region, 3 of which participate in STRIPPS, and 1 FQHC.
8 of 9 counties in STRIPPS are Health Professional Shortage Areas for MCD populations. Health care is not easily afforded across the region: median household income is 17% lower than NYS ($47,834 vs. $57,683); per capita income is 23% lower ($24,751 vs. 32,104); and MCD is a viable solution to receive healthcare resources. There are 3 free health clinics in the Region but they have limited hours and capacity. STRIPPS will enhance this service modality. While there are a number of urgent care centers and ERs in the region, which provide good emergency coverage, these establishments are not venues for primary care.The ratio of population into physicians is 1510:1 vs overall NY of 1216:1 and best US performers of 1051:1.
Specialty care and ambulatory surgery are concentrated in the larger population centers within most counties thus limiting rural residents. Across STRIPPS there is also shortage of mental health providers-psychiatrists, psychologists, licensed clinical social workers, counselors, and advanced practice nurses specializing in mental health care. The ratio of population to mental health providers is 617:1, vs the overall in NY of 510:1.
The provider model needs to be modified to increase in the number of primary care providers—be it physicians or mid-level providers—to engage in primary preventive and population health care, co-locate mental and behavioral services, and assist in providing education about other community health resources. Where there are provider shortages, STRIPPS proposes that alternative health engagements need to be made, like telemedicine and mobile service units (i.e. crisis stabilization, etc). Care of MCD members is presently fragmented making care transitions and cohesive delivery difficult. Improving the communication and availability of health information is imperative. All focus groups stated that hours of operation are a limiting factor. There are <10 primary care offices with non-traditional hours ranging from 7-9pm in the evening, but this is concentrated to more urban areas of STRIPPS. Determining how to offer primary care services during non-traditional times will be addressed by the selected projects.

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	56	9
2	Food banks, community gardens, farmer's markets	201	22
3	Clothing, furniture banks	54	0
4	Specialty educational programs for special needs children (children with intellectual or developmental disabilities or behavioral challenges)	48	7
5	Community outreach agencies	59	20
6	Transportation services	194	0
7	Religious service organizations	41	0
8	Not for profit health and welfare agencies	59	13

United Health Services Hospitals, Inc (PPS ID:44)

#	Resource Type	Number of Resources (Community)	Number of Resources (PPS Network)
9	Specialty community-based and clinical services for individuals with intellectual or developmental disabilities	39	9
10	Peer and Family Mental Health Advocacy Organizations	24	5
11	Self-advocacy and family support organizations and programs for individuals with disabilities	63	8
12	Youth development programs	75	0
13	Libraries with open access computers	126	0
14	Community service organizations	40	7
15	Education	98	0
16	Local public health programs	15	13
17	Local governmental social service programs	26	10
18	Community based health education programs including for health professions/students	39	7
19	Family Support and training	75	36
20	NAMI	7	0
21	Individual Employment Support Services	34	5
22	Peer Supports (Recovery Coaches)	27	7
23	Alternatives to Incarceration	23	0
24	Ryan White Programs	25	14
25	HIV Prevention/Outreach and Social Service Programs	37	21

***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.

Assistance accessing healthy food options and transportation options is needed due to the rural nature of the Region. There are numerous organizations within the regional community that address these social health factors including 202 food banks/pantries. As shown in the County Health Rankings by the RWJ Foundation, within the Region, there's a higher percentage of the population who are low income and do not live close to a grocery store as compared to the state average (4% vs 2%). 304 transportation organizations serve the elderly, disabled, and Medicaid beneficiaries. Transportation in rural areas is especially difficult for people without a driver's license or means of transportation to get to appointments or care delivery sites.

Serving the Region's educational needs including heath professional education are 91 school districts, 8 institutions of higher education including 2 state universities, an Ivy League school, 2 private colleges, 3 community colleges, and 39 community based programs. 75 programs focus on providing support for specialized populations like adult care-givers, children with emotional disturbances, and family support and training.

In the Region, 70 agencies provide housing or housing assistance for individuals in economically disadvantaged situations. These programs also ensure that housing options are safe and habitable. 25 agencies provide outreach and social service programs to individuals with HIV/AIDS, some of which also provide housing services.

Local governments have 26 agencies such as Medicaid offices and the Offices of the Aging providing a variety of support services. 39 specialty community-based offer clinical services for individuals with intellectual or developmental disabilities. 63 programs provide self-advocacy and family support; 24 peer and family mental health advocacy organizations offer assistance.

Regionally, substantial community resources exist but lack integration with other services. The lack of integration leads to inefficient delivery of care and failures to meet all needs. Duplicative services exist within the Region as a result of efforts to minimize commuting distance across rural distances for people to access services hence resource distribution is less of a problem. Transportation is a high need among Medicaid beneficiaries as identified in the CNA. The process for booking, confirming and actually being transported by one of these services is difficult and onerous. It is difficult for a patient to be compliant with health care obligations and maintain social productivity and functionality when one has to maintain a 2-hour window of availability both prior to and following the desired pick-up times.

Mental health resources are limited. The rural environment is not conducive to support multiple mental health locations so strategies

United Health Services Hospitals, Inc (PPS ID:44)

identified in Projects 3ai Integration of Primary Care and BH and 4aiii Strengthen MH and SA infrastructure will be facilitate delivery of service those in need.
Modification of community resources to address access will be part of the project implementation and will be prioritized based on identifying how the greatest number of MCD/UI can be served.

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:

STRIPPS is a 9 county region which in 2013 had an estimated 702,201 residents of whom 210,473 were MCD (STRIPPS 30% vs NYS 34%). The population in this region is older than statewide with a lower percentage of residents 18 years or younger (STRIPPS 19% vs NYS 22%), a greater percentage age 65 or older (STRIPPS 18% vs NYS 14%) and age 85 or older (STRIPPS 3.2% vs NYS 2.2%). One third of MCD are under age 18 (STRIPPS 33% vs NYS 35%). There is a larger proportion of residents age 18-24 (STRIPPS 13% vs NYS 10%) and a smaller proportion of residents age 25-44 (STRIPPS 22% vs NYS 27%), reflecting the outmigration of college populations. The median age is lower in counties with colleges and higher in non-core (rural) counties. For the MCD population, 39% of members are age 18-44 and higher than statewide (NYS 36%). The geographic variation in age distribution suggests that rural areas have a larger proportion of older individuals who are more likely to have health needs. Attachment 2/2a.

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

STRIPPS population is 92.9% white with rural areas less diverse than urban areas and significantly less than statewide. MCD has a higher proportion of Black and Hispanic than the Region (Black 5.9% for MCD vs. 3.4% for region, Hispanic 3.3% for MCD vs. 2.7% for the region). Similarly, over 55% of MCD are female though they comprise only 50% of the regional population. Some of these differences may be accounted for by the higher proportion of females (16.1% female vs. 14.3% male) and minorities (Black 39.4%, Asian 32.2%, Hispanic 30.5%) who are below the federal poverty level (FPL).

The majority over age 5 speak only English (93.1%). Indo-European (2.9%), Spanish (1.9%), Asian/Pacific Islander (1.8%) are the main languages other than English. Of these, 30% speak English less than very well. A larger proportion of the Region as compared to NYS is native born (95.4% vs. 78.0% in the US and 75.5% vs. 63.8% in NYS). Workforce development and projects will address health literacy.

***Demographics 3:**
Income levels:

Median household income in the region is 17% lower than NYS ($47,834 vs $57,683) and per capita income is 23% lower ($24,751 vs 32,104). income for households headed by females is roughly 70% of male-headed households, and over 55% of MCD are female though they comprise only 50% of the regional population. In general, income disparities are highest for Black/African American residents who earn a fraction of the income earned by Whites (as low as 40% in some counties) whereas income for Asian residents in most counties is higher than that for Whites. There is a higher proportion of widows as well as divorcees of both genders as compared to NYS. As well, there are also higher percentages of non-relative and unmarried partner households and households with one or more persons over age 65. Not surprisingly, a larger percentage of residents in this region receive retirement income (STRIPPS 24% vs NYS 18%) and Social Security income (STRIPPS 34% vs NYS 28%).

***Demographics 4:**
Poverty levels:

113,000 STRIPPS people (15.2%) live below FPL (higher than NYS 14.9%).FPL is higher for ages 18-64 (STRIPPS 15.3%, NYS 13.5%). STRIPPS FPL is high among children (20.2%), those with less than a high school education (24.0%), and unemployed (males 25.2%, females 33.7%). Poverty rates reflect income disparities for females (below FPL:16.1% females,14.3% males) and minorities (below FPL: Black 39.4%, Asian 32.2%, Hispanic 30.5%,White 13.7%). Highest poverty rates: families with related children under age 5 and

United Health Services Hospitals, Inc (PPS ID:44)

households with unrelated individuals over age 15. In most counties, poverty rates for families who only have children under age 5 are over 50%;in households with unrelated people; 50% counties have poverty rates over 25%.
STRIPPS UI (72,000) is higher for racial/ethnic minorities, foreign born, low education, unemployed. UI are less likely to recognize/seek treatment for chronic health conditions resulting in poor disease management, severe disease states, and increased HC costs.

***Demographics 5:**

Disability levels:

Among non-institutionalized, those with a disability is higher in STRIPPS region than NYS (14% vs 11%) and highest in Chenango County (16%). Older population segments have a higher disability rate than younger ones (35% age 65+ vs 11% age 18-64). Regional minority populations have a higher rate of people with a disability than Whites (Native American 24%, Pacific Islander 22%, Black 17%,White 14%). The most common disabilities:1)age 18-64 are ambulatory, cognitive, and independent living; 2)over age 65:ambulatory, hearing, and independent living. The Region has a higher rate of MCD people who are blind and disabled than NYS for those who receive MCD only (14% vs 11%) and for those who receive both MCD and SSI (7.1% vs 3.9%),with the highest percentages in rural counties.

Rural residents' limited access to transportation, health services and social participation may result in poorer physical and mental health, increased need for health services, and higher medical costs.

***Demographics 6:**

Education levels:

Colleges or universities are located in three STRIPPS counties (Tompkins, Cortland, and Broome) which are home to a generally younger more educated population. In rural counties (Delaware, Schuyler, and Chenango), the median age is higher as is the percentage of individuals with less than a high school education. Still, counties with the highest proportion of low educational attainment are only about two-thirds of the statewide percentage (Steuben 4.3% vs NYS 6.9%). In comparison to NYS, the Region has a greater proportion of those with a high school diploma (34% vs 27%) or an associate's degree (12% vs 8%) though fewer residents have bachelor's, graduate, or professional degrees. Low educational attainment, and in particular, those with less than a high school education have lower incomes, higher unemployment, experience greater poverty, and are less likely to have health insurance.

***Demographics 7:**

Employment levels:

For 2013-2104, employment in the STRIPPS region was slightly less than NYS (5.9% vs. 6.1%). Over the past four years, the proportion of the population not in the labor force has been higher in the Region than in NYS (39% vs 36%). People in this category include those who are going to school or are retired, those whose family responsibilities keep them from working, and those who have given up trying to find a job. In this Region, the number of individuals not in the labor force (43%) and the percent unemployed (6.9%) were higher for women than for the general population. The percent of families in which both parents work was higher in the Region than NYS for those with children under age 6 (68% vs 63%) and for those with children ages 6-17 (76% vs 70%). Major employment sectors include education, healthcare, and social services; and compared to NYS, the region has a more government (18.4% vs 16.5%) and self-employed workers (7.0 % vs 6.0%).

***Demographics 8:**

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

In the Region, 38 skilled nursing facilities have a bed capacity of 4931; average occupancy 94% . Of those receiving nursing home services in NYS, 79% are MCD receiving long-term care. Nursing home residents account for 1/3 of MCD long-term beneficiaries and 53% of spending. Nursing home residents have cognitive impairment (67%), psychiatric diagnoses (56%), and behavioral symptoms (27%). They average 6 multiple diagnose per resident with complex medical conditions including cardiovascular (82%), neurologic (75%), and musculoskeletal (42%), and diabetes (32%). The criminal justice system operates two maximum security state facilities in Chemung plus each county has a jail. Chronic infection with HIV as well as Hepatitis B and C are more prevalent among the incarcerated. The inmate population is aging resulting in increases in healthcare needs. Leading causes of death are heart disease, cancer, AIDS, and liver disease and reflect higher rates of high risk behaviors/ substance abuse.

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

United Health Services Hospitals, Inc (PPS ID:44)

As necessary, please include relevant attachments supporting the findings.

File Name	Upload Date	Description
44_SEC034_Section 3.Attachment 1.STRIPPSMetricsDescDataAnalysis.pdf	12/22/2014 07:17:40 AM	
44_SEC034_Section 3.Attachment 2.STRIPPS.CNA.Demographics.pdf	12/22/2014 07:17:17 AM	
44_SEC034_Section 3.Attachment 2a.STRIPPS.CNA.Demographic Dashboard.pdf	12/22/2014 07:16:58 AM	
44_SEC034_Section 3.Attachment 3.STRIPPS.CNA Health Indicators.pdf	12/22/2014 07:16:44 AM	
44_SEC034_Section 3.Attachment 3a.STRIPPS.CNA.Health Indicators Dashboard.pdf	12/22/2014 07:16:17 AM	

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:

In 2012, the leading causes of death within the Region included: heart disease, cancer, chronic lower respiratory disease, stroke, and unintentional injury. For this same year/region, leading causes of premature death were cancer, heart disease, unintentional injury, and chronic lower respiratory disease. Heart disease and cancer were the leading causes of death and premature deaths among both men and women accounting for about half of all deaths. Chronic lower respiratory disease was the third leading cause of death among both men and women as well as a leading cause of premature deaths. Heart disease and cancer are also leading causes of death across all racial/ethnic minority populations. In four of the ten counties, diabetes was the fifth leading cause of premature death; and over the past ten years, has become one of the top five leading causes of death for Black, Asian, Native American and Hispanic New Yorkers. For half of the counties, suicide was the fifth leading cause of premature death. This substantiates the need for projects 3bi CV Disease management, 4bii Prevention/Management of COPD, 3ai Integration of PC and BH, and 3aii Crisis Stabilization (see Attachment 3/3a).

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

Leading causes of hospitalizations are diabetes, cardiovascular disease (CVD), heart disease, unintentional injury, coronary heart disease, falls, chronic lower respiratory disease, congestive heart failure, pneumonia/flu, and cerebrovascular disease. CVD accounts for 4 of the top 10 conditions.
MCD hospitalizations (97,553; 37.9% of Region) represent a disproportionate share of disease morbidity. Top 10 underlying causes of hospitalization for medical and psychiatric conditions included: hypertension, depression, diabetes, asthma, obstructive lung diseases, stress and anxiety diagnoses, depressive and other psychoses, chronic alcohol abuse, schizophrenia, and coronary arteriosclerosis. 60% of counties had age-adjusted preventable hospitalization rates that were higher than the Upstate average. MCD adjusted hospitalization rates were higher than NYS for all acute conditions, including chronic obstructive pulmonary disease, asthma, and heart failure. Hospitalization rates support the selection of projects 3bi CV Disease Management, 4bii Prevention/Management of COPD and projects 3ai, 3aii and 4aiii related to behavioral health.

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

In just over half of the counties, emergency room visits were above statewide averages. Among Medicaid beneficiaries, the top ten underlying causes of hospitalization for medical and psychiatric conditions include: depression, hypertension, asthma, chronic stress and anxiety diagnoses, schizophrenia, diabetes, depressive and other psychoses, bipolar disorders, obstructive lung diseases, and chronic alcohol abuse. In 2013, there were 250,089 emergency room visits. Emergency room visits were highest among 18-44 and 45-64 year olds and lowest among children ages 6-11. Three-year trend analysis revealed increasing visit rates for all adult age groups, though overall emergency room visits have trended downward since January 2012. This data supports selection of projects 2ci Community Based

United Health Services Hospitals, Inc (PPS ID:44)

Management, 2di Patient Activation and 2ai Integration of the Delivery System with project activities geared to direct people to the most cost effective and appropriate setting for receiving health care.

***Challenges 4:**

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

Among counties in this region, the prevalence of hypertension among adults ranged between 24% and 32.5%, and is higher than the 25.7% in NYS for 88% of counties. The prevalence of diabetes ranged from 7.4% to 12.1% in STRIPPS counties; and in half of the counties, the prevalence was greater than NYS (9.0%). In STRIPPS counties, the age adjusted percentage of adults with physician diagnosed angina, heart attack, or stroke ranged from 6.1% to 11.2%; and for half of the counties, the prevalence of these conditions was greater than NYS (7.6%). Across counties in the region, obesity among elementary school children ranged from 15.7% to 21.9% and among middle and high school students from 14.4% to 25.7%. Among children aged 2 to 4 years in the WIC program, the prevalence of obesity was above the NYS average (14.4%) for the majority of counties (12.4% to 16.0%). Among pregnant women in the WIC program, the prevalence of pre-pregnancy obesity was higher than NYS (24.2%) across all counties in the region (26.8% to 34.2%). The age-adjusted percentage of adults with obesity was higher than NYS (23.1%) for 89% of counties (24.1% to 34.9%).

Obesity, hypertension, and diabetes are three of five medical conditions identified as increasing metabolic risk for cardiovascular disease. Lifestyle behaviors including smoking, poor diet, and physical inactivity contribute to obesity, hypertension, and diabetes as well as to the burden of cardiovascular and cerebrovascular diseases. An estimated 18.1% of deaths can be attributed to tobacco use, 15.2% to poor diet and lack of physical activity, and 3.5% to alcohol use. Together, these risk factors account for more than a third of all deaths in the United States. For 88% of counties in the STRIPPS region, the prevalence of smoking was higher than in NYS (STRIPPS 12.5% to 30.8% vs NYS 17.0%). While physical inactivity in this region is similar to NYS where 23.7% of adults did not participate in leisure time physical activity in the past 30 days, the age-adjusted percentage of adults who ate five or more fruits and vegetables per day was lower than NYS (27.1%) for 63% of counties in the region (22.5% to 33.1%).

The age-adjusted percentage of adults with self-reported poor mental health for 14 or more days during the past month was higher than Upstate NY for 44% of counties (STRIPPS 6.8% to 21.2% vs Upstate NY 17.4%) and higher than the NYS 2017 Prevention Agenda target of 10.1% for two-thirds of them. Similarly, the age-adjusted percentage of adult binge drinking during the past month was higher than Upstate NY and the 2017 Prevention Agenda target for 44% of counties (STRIPPS 11.8% to 24.2% vs Upstate NY 17.4% & Prevention Agenda 18.4%). The age-adjusted suicide death rate was higher than Upstate NY (9.5 per 100,000) for two-thirds of counties in the region; and rates in all counties were higher than the NYS 2017 Prevention Agenda target of 5.9 per 100,000. The prevalence of chronic disease, poor mental health, and associated lifestyle risk factors present challenges to improving the health of residents in this region and are the primary focus of this application.

***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:

Adolescent and unintended pregnancy rates, and live births within 24 months of a previous pregnancy are higher than statewide averages. % of unintended MCD pregnancies was higher than NYS in 40% of counties. 1/3 of counties had higher neonatal (<7 days of life) infant mortality (4.3-5.5 vs. NYS 3.5). 2 counties have higher average maternal mortality rates (65.9, 74.1 vs. NYS 22.4).% of births with early/adequate prenatal care was higher than NYS averages (69.5 – 82 vs. NYS 65.9) contributing to lower incidence of preterm birth rates in 7 0f 9 counties (6.4-7.9 vs. NYS 8.2). % of infants fed any breast milk in hospitals was lower than NYS in nearly all counties yet the percentage of infants fed exclusively breast milk was higher. For women in WIC, breastfeeding lasting > 6 months was lower than NYS. 50% of the counties had a higher prevalence of diabetes and 70% had more prevalent hypertension than NYS, conditions associated with greater maternal weight and gestational weight gain. In half the counties % of children ages 3-6 in government programs with recommended well child visits was below state averages (67.7-71.9 vs 79) and for ages 12-21 only one county exceeded NYS.

***Challenges 6:**

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

Regional rates of self-inflicted injury hospitalizations, self-reported poor mental health, and binge drinking were higher than NYS in two-thirds of counties. For those with diagnoses related to mental illness and chronic disease, the difficulties of managing one's health are compounded. Mental health disorders(depression, stress and anxiety, schizophrenia, bipolar,substance abuse) are more prevalent in the MCD population than in the general population. The proportion of those with both mental and physical health disorders is higher among MCD particularly for diabetic, cardiovascular, and obstructive respiratory conditions. Hospitalization and emergency room visit rates are

United Health Services Hospitals, Inc (PPS ID:44)

considerably higher for dual eligibles. These individuals experience greater poverty, have more complex healthcare needs, and incur greater healthcare expenditures. All research modalities identified access to mental health as a priority, highlighting increased access to substance abuse treatment and prevention. IDI research validated that the need for improved communication between provider segments to achieve chronic disease and MEB patient outcomes may be addressed through projects 2ai, 2ci, 2di, 3ai, 4aiii.

***Challenges 7:**

Any other challenges:

The Region's large geographic area is a compounding factor for the identified health issues. The Region's population is 210,473 with 94,000 MCD/54,000 UI lives from 9 counties: Broome, Chemung, Chenango, Cortland, Delaware, Schuyler, Steuben, Tioga, and Tompkins. The service area is 7,352 square miles with a population of 786,598 yielding a population density of 107 people per square mile. The Region is predominantly rural with 4 small metro counties (Broome, Chemung, Tioga, and Tompkins), 2 micropolitan counties (Cortland, and Steuben), and 3 noncore counties (Chenango, Delaware, and Schuyler). The largest population centers are: Binghamton (Broome), Ithaca (Tompkins), Vestal (Broome), and Cortland (Cortland Co). A resident choice of where to live must be taken in to account when distributing resources and improving outreach and access as part of implementing projects to achieve DSRIP goals. Projects focusing on integrating care (2ai IDS and 3ai Integration of PC/BH) by utilizing EHR, care coordination and telemedicine activities incorporated in several projects (2ai,2biv,2bvii,3ai, 3aii, 3bi) can help minimize the impact of geography on the access to and delivery of care.

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**.

As identified previously, there is a shortage of primary health providers, dentists and mental health professionals within the area.
The primary health service gaps are most prominent for appropriate management of chronic conditions like diabetes, or cardiovascular conditions like hypertension and obesity. As shown through the quantitative analysis, the prevalence of these conditions are higher in the STRIPPS region than NYS. Medicaid beneficiaries with these conditions are present across all counties but the largest population of these individuals is within Broome County. Broome County additionally has the highest proportion of potentially preventable emergency room visits (PPV) and overall potentially avoidable hospital admissions (PQI).
In order to reduce PPVs and PQIs, there needs to be an engagement with primary care providers and community-based organizations to defray these incidences.
Because of the rural environment throughout much of the STRIPPS region, there are numerous community organizations. However, coordination of care delivered by these organizations needs to occur in order to improve the health outcomes for MCD/UI. The focus groups revealed key drivers to ER use, identified by the participants, are: 24/7 access; lack of knowledge as to where else to go to receive care; shortage of other healthcare resources (providers); and no out-of-pocket, up front costs. Other significant drivers also include: ready transportation to the ER, ability to access multiple services (X-ray, lab, specialists, medications) from one location.
Enhancements need to be made to the primary and preventive health network, including potentially bolstering the free clinics given the limited number of Medicaid providers (project 2di), improving the hours of availability, assisting individuals in their ability to navigate the health system and health resources (project 2ci), co-locating services to minimize transportation requirements and maximize engagement opportunities (project 3ai) and improving the communication between community resources and providers to improve specific health needs (project 2ai, 3bi).
Presently there are 1,223 hospital beds attributed to the PPS. Presently, all of the hospitals in the PPS are running below 70% occupancy. STRIPPS is seeking to consolidate double occupancy rooms to single occupancy to allow for treatment of higher acuity patients, gain efficiency's and have a reduction of hospital beds. There are approximate 3400 nursing home beds in the region and, the nursing homes in the region presently operate at full capacity. Since the nursing homes are a lower facility, we anticipate a reduction in the cost of care through the objectives of project 2bvii, while improving health outcomes.

***Gaps 2:**

Include data supporting the causes for the identified gaps, such as the availability, accessibility, affordability, acceptability and quality of health

United Health Services Hospitals, Inc (PPS ID:44)

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.

Qualitative research conducted through the on-line survey, individual indepth interviews, and Medicaid/Unisured focus groups identified 17 collective major themes such as (Attachments 5&6 and project narratives): there is a need for ready access to mental health and substance abuse services is the number one priority identified by health care providers and community agencies); access to transportation for non-ED related healthcare provider and community resources; healthcare needs to be more affordable to promote engagement; providers need to offer better hours to access non-emergent healthcare services, including weekend hours and alternative access, e.g., tele-health; all research modalities agreed that there is a need for an integrated delivery system and coordination of care; need to have centralized resources to advise patients on where to go for appropriate care; and there needs to be improved eduation regarding the quality of care provided by non-physician care providers e.g. PAs, NPs The top three needs expressed by the Medicaid and Uninsured were: affordable healthcare, accessibility of dental services and the need for more care options (more doctors/clinics/hours/programs). STRIPPS Region metrics for avoidable admissions and readmission, and unnecessary ER visits being higher than NYS suggests the need for integrative delivery model solutions and for services identified in the 11 projects.

***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 strategies needed to address the identified health gaps in chronic disease, mental and behavioral health issues are multi-faceted. First and foremost, STRIPPS must develop an integrated delivery system to enhance communication across numerous agencies and track strategies used to improve health outcomes. Community navigators are additionally needed to assist Medicaid beneficiaries in engaging with the primary and preventive health resources. Care coordinators are needed in nursing homes and in other transitional settings (movement from the acute enterprise) to ensure that patients are set-up with the resources needed to maintain optimal levels of care within their home environments.

STRIPPS recognizes that engagement of the UI/LU population is key to improving the health of the regional population. As such, identifying these segments of the population though potential "hotspot" areas is important and linking them up with the appropriate health resources is integral to this effort.

The focus group participants clearly indicated that hours of operation and transportation were barriers to receiving care in a primary setting. To mitigate these circumstances, changes need to occur to PCP hours or free clinic hours in the areas with the highest number of Medicaid lives. In more rural areas, novel approaches, like tele-health, need to be used to allow for remote monitoring of chronic issues. Due to transportation barriers, concentration of services, like the integration of primary and mental health care need to occur to ensure that a patient is easily contained within the system and can access multiple resources through one venue.

All identified projects successfully tested with the focus group participants. Future project concepts will be vetted with the Patient Advisory Panel, identified through the CNA process. 81%, or 1,338, of those participating in the on-line survey expressed a willingness/desire to continue to provide input on project design. The 1,338 Patient Advisory Panel is comprised of 15% health care providers, 22% community agencies, and 63% of the at large community (846), of which 240 were Medicaid beneficiaries and 65 Uninsured.

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).

STRIPPS completed a multi-faceted Community Needs Assessment (CNA) comprised of a review of existing local DOH and hospital CHNA/CHIPS, DSS Mental Health Hygiene Assessments, NYSDOH data, and new quantitative/qualitative research. Agencies serving the MCD/UI conducted a Provider and Community Resource study which identified the Region's service gaps/lack of services and capacity to implement the selected projects.

PPS stakeholders/PAC were actively engaged in all key decisions pertaining to assessment recommendations, analytic and intervention

modalities, and provided guidance for the data gathering tools designed to gather key perceptions related to community health issues and DSRIP goals. Stakeholders/PAC/vendors/project leaders were engaged in the CNA process through 3-4 weekly meetings, webinars, and conference calls. This group provided input on the design of the research tools, community survey, IDI and focus group discussion guides, and interpretation of research to ensure that the most appropriate projects were selected to achieve DSRIP goal. Healthcare providers, community leaders, residents, MCD beneficiaries/UI were engaged in CNA primary and secondary research through weekly meetings and bi-weekly Stakeholder/ PAC meetings.

Quantitative (predictive modeling) and qualitative research (Surveys/ IDI /Focus Groups) was used to select and construct the 11 identified projects. Input was elicited from stakeholders/project leads on who should be interviewed (healthcare providers/community agencies working with MCD/UI) and the best methods to reach the targeted populations. Based on this input 15 focus groups were conducted, the number per county based on geography MCD/UI density. Focus groups were comprised of MCD/UI. Project interventions and transformative principles were tested for potential impact with focus groups.

Over 500 MCD/UI provided input on the projects, and agreed to continue to inform the project design process through a Patient Advisory Panel over the 5 year grant period. Healthcare provider (physicians: primary care, geriatrics, palliative medicine, psychiatrists, OB/GYN; advanced practice nurses, social work etc.) and community leaders (nursing home administrators, transportation, office for aging, churches, school, DSS, county DOH etc.) provided input through an on-line survey and 90 interviews. See Attachment 4.

***Community 2:**

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

Across STRIPPS 2011 on line surveys were completed (completed (57.7% by community residents; 32% of the community residents or 375 were MCD/UI), 90 In-depth Individual Interviews ("IDI"-38 with healthcare providers, 52 community agency associates), and 15 focus groups comprised of 126 Medicaid beneficiaries/uninsured were conducted. 68% or 1,363 persons involved in the research indicated that they would be willing to continue with further research throughout the project design, development, implementation, and evaluation. The 126 beneficiaries were selected through a combination of outreach emails, flyers, phone calls, workgroups, websites, and through social media. Those with direct involvement with the MCD/UI were strongly encouraged to participate. MCD/UI first participated in the online survey and then were given the option to participate in future research which involved a follow-up IDI by telephone. MCD/UI online survey was not mandatory for the IDI. MCD/UI were recruited across STRIPPS and special attention was paid to ensure feedback was received across all counties and from both the healthcare and community leader audiences.See Attachment 4.

***Community 3:**

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

STRIPPS CNA identified several key findings, insights, and conclusions based on primary research conducted. These conclusions were drawn from an online survey, in-depth interviews (IDIs), and focus groups administered among key community stakeholders across the Region. Key findings include: 1) MCD in the Region are largely unaware of healthcare service options available to them beyond the ED. 2)the need to better educate the population on preventive health behaviors and provide information on appropriate ED use. 3) Financial barriers push MCD/UI to seek options that offer no out-of-pocket expenses at visit, which was a key advantage to ED usage. 4)Factors that contribute to inappropriate ED visits and re-admissions include low usage of PCPs, lack of transportation, lack of medical and dental providers accepting MCD, and a lack of known after-hours healthcare settings. 5) Healthcare providers also discussed the low MCD reimbursement of which MCD recipients were aware. MCD believe this low reimbursement impacted the quality of care they received and the availability of appointment times they were offered. See Executive Summary, pgs 13-53, Attachment 4.

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.

[United Health Services Hospitals, Inc] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
1	Susquehanna Nursing and Rehabilitation Center	The interdisciplinary team of professionals at Susquehanna works with each resident to ensure	This organization deals with elderly Medicaid recipients on a daily basis

United Health Services Hospitals, Inc (PPS ID:44)

[United Health Services Hospitals, Inc] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		continuity of care to offer every opportunity for maximum functioning through a comprehensive care plan. The staff includes RNs, LPNs, and CNAs who work closely with each resident to ensure the highest standard of patient care possible. It also offers adult day care and home health care options.	throughout its wide array of services. Presumably has consistent involvement of patient transfers to the ED if needed from elderly patients.
2	NYS Office for People With Developmental Disabilities	The New York State Office for People With Developmental Disabilities (OPWDD) is responsible for coordinating services for more than 126,000 New Yorkers with developmental disabilities. It provides services directly and through a network of approximately 700 nonprofit service providing agencies, with about 80 percent of services provided by the private nonprofits and 20 percent provided by state-run services.	OPWDD provides support and services, which include Medicaid funded long-term care services such as habilitation and clinical services, as well as residential supports and services, are primarily provided in community settings across the state.
3	The Family and Children's Society	This agency consists of a dedicated staff, board of directors, and volunteers who have promised to serve with compassion and integrity. Responsiveness and flexibility have helped The Family & Children's Society remain a stable and reliable place to turn to for help for more than 70 years.	As a leading community provider of human services, their goal is to help people improve the quality of their lives. The Family and Children's Society is committed to renewing hope for those who face challenges due to troubling circumstances. This commitment translates into assistance, care and counseling that serve to strengthen and support individuals and healthy relationships.
4	Allergy Asthma & Immunology Center	Private health practice that has nearly 30 years of experience in the practice of allergy and immunology.	The center is dedicated to the treatment of allergic and immunological problems of adults and children. This organization often deals with Medicaid recipients.
5	United Health Services	A leading health care provider that has more than 500 physicians on its Medical Staff and 60 locations.	UHS is a comprehensive regional health system whose mission is to improve the health of those they serve, which includes Medicaid recipients and uninsured populations. As a community-based system, the values that guide decision-making and behavior should reflect the culture of its communities.
6	The Decker School of Nursing at Binghamton University	DSON prides itself on both the quality and the quantity of its clinical practice experiences that are seen as the foundation for graduates' success in professional practice. Prior to graduating, students complete hundreds of hours of off-site clinical rotation experiences in acute care and community settings as part of course work.	Presumably deals with the Medicaid and uninsured populations.
7	Lourdes Memorial Hospital	The main hospital campus includes a Hospice Program, an Ambulatory Surgery Center, and a Regional Cancer Center. Reaching beyond these boundaries, Lourdes has established a network of primary care physicians at convenient sites throughout the region.	Hospital services are available to the extent resources allow to all persons seeking those services, regardless of race, creed, sex, disability, or socioeconomic status.
8	Update Medical University	The Upstate University Health System serves 1.8 million people, often the most seriously ill and injured, and includes Upstate University Hospital; Upstate University Hospital at Community Campus; Upstate	SUNY Upstate Medical University improves the health of the communities it serves through education, biomedical research and

United Health Services Hospitals, Inc (PPS ID:44)

[United Health Services Hospitals, Inc] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		Golisano Children's Hospital, and numerous satellite sites.	health care. Upstate often services Medicaid and uninsured populations.
9	Broome County	Government organization in that provides a broad array of services for residents to access.	Often communicates and services residents with Medicaid or those without insurance (e.g. Department of Social Services, Health Department, Mental Health, etc.).
10	Actions for Older Persons	Action for Older Persons (AOP) is a private not-for-profit organization that enhances the lives of adults living in Broome and Delaware counties. Through their classes, seminars, counseling sessions, and advocacy, AOP volunteers and staff impact the lives of thousands of people each year.	AOP empowers individuals and families by providing unbiased information about health insurance options, advocacy, and education to promote quality of life.
11	Monroe Plan for Medical Care	Monroe Plan for Medical Care is a health care services organization, which has been meeting the needs of low income and government sponsored populations in Upstate New York for over 40 years.	They have strong support from over 15,000 health care professionals serving in excess of 250,000 individuals enrolled in Medicaid Managed Care, Child Health Plus, and Family Health Plus covering Medicaid eligible children, families, the aged, blind and disabled.
12	Mental Health Association of the Southern Tier, Inc.	The Mental Health Association of the Southern Tier, Inc. is a private, not-for-profit organization established in 1927, affiliated with the New York State and National Mental Health Associations and one of 300 Mental Health Associations nationwide.	The organization is devoted to enhancing the lives of all community residents, including Medicaid and uninsured populations, by improving their mental health and wellness. Organizational goals are achieved through advocacy services, educational presentations, prevention programs, information and resource referrals.
13	Rural Broome Counts	Rural Broome Counts (RBC) is a needs-assets assessment project that will take a deeper look at the eleven rural townships in Broome County (townships with 200 people per square mile or less). RBC will be completed by August 2015 at which time a report will be distributed for use by all stakeholders.	A representative from RBC was interviewed to provide feedback regarding healthcare related perspective gained from working on the community health assessment.
14	The Institute For Human Services, Inc.	The Institute for Human Services is a not-for-profit management support organization founded in 1984. The Institute provides management support, information and referral, organizational development, research and technology services to planners, funders and providers serving the Southern Tier of New York State.	The Institute for Human Services serves as a model for excellence in not-for-profit management and will be recognized by planners, funders, and providers as the first point of contact for nonprofit management solutions in the Southern Tier.
15	The Family & Children's Society	The Family & Children's Society offers a variety of services which range from mental health care to home care. These services are available for families, seniors, adults, and youth.	The Family & Children's Society strives to renew hope, provide help, care, and counseling, and to strengthen people through all stages of life.
16	Department of Family Services	Government organization that consists of two offices; The Office of Temporary & Disability Assistance, and The Office of Children and Family Services.	Presumably deals with the Medicaid and uninsured populations.
17	Family Planning of South Central New York	Family Planning of South Central New York advocates and provides individuals, families and organizations in their region with information, education and health care services pertaining to human sexuality and reproductive health in a private	FPSCNY provides health related educational programs for youth and parents across Broome, Chenango, Delaware, and Otsego counties. Family planning educational

United Health Services Hospitals, Inc (PPS ID:44)

[United Health Services Hospitals, Inc] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		and confidential manner, respectful of all beliefs, supporting individual freedom of choice and responsibility.	programs are offered in Delaware, Otsego, and Chenango counties.
18	Southern Tier Aids Program	The Southern Tier AIDS Program provides supportive services to HIV+ persons and state of the art prevention education from 9 offices in an 8 county area.	Services focus on the health and well being of HIV+ persons and incorporate a harm reduction perspective and recognize that behavior change is a gradual process.
19	Diabetic Care Associates	Diabetic Care Associates provides a multi-disciplinary approach for managing specific medical needs.	The primary focus of the practice is the treatment and management of diabetes, hypertension, and hyperlipidemia.
20	United Methodist Homes	United Methodist Homes' communities provide a wide range of senior living services such as full continuum of care, from independent living through skilled nursing care, plus short-term rehabilitation services.	A Social Worker from Elizabeth Church Manor with United Methodist Homes was interviewed regarding her experience serving Broome county residents.
21	The YMCA of Broome County	Located in downtown Binghamton, the facility offers a wide array of opportunities ranging from child care to swim lessons, housing to group exercise, racquetball to volleyball.	The YMCA is committed to strengthening the community. Every day, they work side-by-side with neighbors to make sure that everyone, regardless of age, income or background, has the opportunity to learn, grow and thrive.
22	Binghamton SUNY Clinical Campus	The Binghamton SUNY Clinical Campus was established as a branch campus of the College of Medicine in 1976. Although the Clinical Campus is community-based (clinical facilities are not University-owned), Binghamton students spend similar amounts of time in hospitals on their rotations.	Often services patients with Medicaid or those without insurance.
23	Doctor Garabed Fattal Community Free Clinic	The Community Free Clinic serves as a multidisciplinary and interdisciplinary educational site for the training of medical students, nurse practitioner students, nursing students, other allied health professionals in medical technology, and graduate physicians.	Medical services and medications are delivered free of charge, by volunteer health care professionals, community volunteers, local participating health care institutions.
24	UHS Diabetes and Endocrinology Center	Provide patients with Diabetes and Endocrinology services.	Presumably deals with chronic disease patients, potentially Medicaid and the uninsured.
25	Independence Awareness LLC	Independence Awareness LLC offers programs aimed at preventing falls in people of all ages.	Independence Awareness LLC works with those who have been discharged from the hospital due to a fall, local CHHAs and health departments.
26	Lourdes Center for Mental Health	Lourdes Center for Mental Health (LCMH) is a New York State Office of Mental Health (OMH) licensed outpatient mental health clinic.	The clinic provides: Psycho-social and psychiatric assessment and treatment; Individual, family and group psychotherapy; and Psychopharmacologic medication management. Their treatment team consists of a Board Certified Psychiatrist, Nurse Practitioners of Psychiatry and Licensed Clinical Social Workers, who work collaboratively to ensure a person centric model of care.

United Health Services Hospitals, Inc (PPS ID:44)

[United Health Services Hospitals, Inc] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
27	Lourdes Primary Care	Hospital-based primary care facility with a staff of doctors and nurses who carry out patient-centered care.	Lourdes Primary Care offers walk-in appointments, laboratory services, x-ray services, and advanced appointment booking for patients.
28	Rural Health Network of South Central New York	Rural Health Network of South Central New York, Inc. strives to advance the health and well-being of rural people and communities.	They work toward optimal individual and community health and wellness, which are supported by: Individuals and families with adequate and affordable health insurance; Accessible, efficient, and collaborative health and human service delivery systems driven by best practice models; Reduction in health disparities for the most vulnerable populations; and Strong community norms for healthy lifestyle choices and optimal physical and mental health.
29	New Beginnings	New Beginnings provides the highest quality of home based services to individuals with a variety of needs.	New Beginnings offers successful transitional services from rehabilitation centers, nursing homes, and assisted living facilities.
30	Auburn Community Hospital	Auburn Community Hospital (ACH) is a not-for-profit, 99-bed acute care facility serving a population of approximately 80,000. ACH is the sole provider of acute and general hospital services in Cayuga County and the surrounding areas, located in the Finger Lakes region of Central New York.	Auburn Community Hospital emphasizes patient-centered health care, whether acute, outpatient or preventive care. It continuously improves the delivery and quality of care by applying physical, financial and human resources.
31	Finger Lakes Community Health	Finger Lakes Community Health is a Federally Qualified Health Center and a provider of health care. They provide comprehensive health care for the community, with numerous centers in the region.	Finger Lakes Community Health focuses on working with the underserved and special populations.
32	Seneca Cayuga ARC	Seneca Cayuga ARC is a not-for-profit agency that provides programs and services for people with disabilities and their families in Seneca County and Cayuga County, NY.	It provides opportunities and choices for treatment, employment, education, recreation, and community living to assist individuals with disabilities, often Medicaid and uninsured populations, in realizing a productive and fulfilling life.
33	Cayuga/Seneca Community Action Agency, Inc.	Cayuga/Seneca Community Action Agency, Inc. strives to respectfully assist people to achieve and sustain self-sufficiency through direct services, education and community partnerships.	Cayuga/Seneca Community Action Agency, Inc. has gained a positive reputation throughout the community for advocating the rights of economically challenged families and individuals and changing society's stereotypes regarding poverty. Every three years it conducts a two county needs assessment of the low-income community. The data derived from the community assessment is analyzed and used to develop programs to fill gaps in services.
34	Cayuga Addiction Recovery Services	Cayuga Addiction Recovery Services provides outpatient chemical dependency services located in Ithaca, New York, they are a team of unique professionals dedicated to providing holistic recovery	Presumably deals with the Medicaid population.

United Health Services Hospitals, Inc (PPS ID:44)

[United Health Services Hospitals, Inc] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		services that recognize and value the innate dignity of each person.	
35	Catholic Charities of Chemung and Schuyler Counties	Catholic Charities provides a number of needed programs and services in this community with a priority toward the poor. Catholic Charities works to ensure that people have food, clothing, shelter, medical services, and the ability to achieve a decent standard of living. It offers programs such as residential services, community support services, public policy advocacy, and parish services.	Catholic Charities is committed to serving all individuals in need regardless of racial, ethnic, cultural or religious origins, ability to pay, as well as mental, physical or developmental challenges.
36	Chemung County Nursing Facility	The Chemung County Nursing Facility is a modern health care center that provides a variety of services, a caring staff and a residential environment.	The Chemung County Nursing Facility is fully accredited by the Medicare and Medicaid Programs and is a member of both the state and national Leading Age Associations. It participates in the voluntary "Quality First Program," a national quality assurance initiative.
37	Basset Healthcare Network	Bassett Healthcare Network is an integrated health care system that provides care and services to people living in an eight county region covering 5,600 square miles in upstate New York.	A Certified Family Nurse Practitioner was interviewed regarding her experiences and perceptions working for the Chenango healthcare system.
38	Catholic Charities of Chenango County	Catholic Charities of Chenango County provides many types of services and support for people in the community. They provide these services to individuals and families in need through the support of state organizations, local foundations, and individual donors.	Catholic Charities of Chenango County are advocates for individuals affected by issues of poverty, abuse, and mental health needs. They seek to promote justice for the underserved and to effect change in society to give a voice to those that have gone unheard.
39	Chenango County	Government organization in that provides a broad array of services for residents to access.	Often communicates and services residents with Medicaid or those without insurance (e.g. Department of Social Services, Health Department, Mental Health, etc.).
40	Hospice & Palliative Care of Chenango County	Hospice of Chenango County provides care for terminal illnesses, palliative care, homecare, or counseling to deal with death and dying.	At Hospice of Chenango County, they believe that the patient matters until the last moment of their life. It provides compassionate end-of-life care for patients and families to help make choices that are right for them.
41	Chenango Health Network	Chenango Health Network is a rural health network whose objectives are to increase access to health and wellness information and to health care services. They serve individuals and work to effect change at the community level.	Chenango Health Network is a community-based rural health network dedicated to improving access to health services.
42	Chenango County Alcohol & Drug Abuse Services	Chenango County Alcohol & Drug Abuse Services provides services such as assessment and evaluation, crisis intervention, school-based prevention services, individual counseling, group therapy, vocational evaluation services, and medication therapy.	Services the needs of adults, children, families, individuals, and couples of Chenango County who are affected by substance abuse
43	Chenango County Area Agency on Aging	Chenango County Area Agency on Aging provides a variety of services such as health and recreation, nutrition, senior centers, legal assistance, in-home care, long term care, as well as other services.	Chenango County Area Agency on Aging provides education about Medicare, Medicaid, managed care, and other health insurance issues. It also assists Medicare beneficiaries

United Health Services Hospitals, Inc (PPS ID:44)

[United Health Services Hospitals, Inc] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			applying for programs such as Medicare Part D (prescription drug plan), EPIC (Elderly Pharmaceutical Insurance Coverage), Low Income Subsidy, and Medicare Savings Program.
44	Chenango County Public Health	Chenango County Public Health strives to ensure that citizens of all ages have access to appropriate health services and education.	Chenango County Public Health works in partnership with the community to promote and protect the health, safety, and quality of life through assessment, education, and by ensuring that necessary health services are available. Often communicates and services residents with Medicaid or those without insurance.
45	CMH Services	Cortland Regional Home Health Services proves easy access to a complete range of home medical equipment and supplies.	Presumably deals with the Medicaid and uninsured populations.
46	Catholic Charities of Cortland County	Catholic Charities of Cortland County is a not-for-profit human service agency that has been helping people help themselves since 1976.	Catholic Charities envisions a better life for people who live in poverty, are vulnerable or disabled, who struggle with recovery, or are troubled.
47	Cortland County	Government organization that provides a broad array of services for residents to access.	Often communicates and services residents with Medicaid or those without insurance (e.g. Department of Social Services, Health Department, Mental Health, etc.).
48	Department of Family Services	The Office of Children and Family Services serves New York's public by promoting the safety, permanency, and well-being of children, families and communities.	In providing services to impaired adults, it is required for Protective Services for Adults to work with agencies dealing with aging, medical, and mental health, legal issues, and law enforcement.
49	HCR Home Care	Since 1978, HCR Home Care's goal has been to provide patients, physicians, and other health care professionals with superior service from referral to post-discharge follow-up.	HCR is committed to providing the best quality patient care. The Centers for Medicare and Medicaid Services tracks patient outcomes for all certified home health agencies in the country. HCR often services Medicaid and Medicare recipients.
50	Family Health Network	Rooted in the geographic center of New York State, in the Crown City of Cortland, NY and surrounding rural areas, FHN works to enhance the health and well being of individuals from underserved, rural communities by providing comprehensive, affordable medical and dental services.	Family Health Network (FHN) is a Federally Funded Community Health Center (FQHC), serving Cortland and contiguous counties. FHN is the only source of care in three of the five communities served, and the only source of sliding adjustments for low-income individuals and families in the Cortland County region. They accept Medicaid insurance.
51	Cortland Regional Medical Center	Cortland Regional Medical Center offers a wide variety of services that range from emergency room care to senior programs, from pediatrics to physical therapy, its doctors, nurses and healthcare specialists are working to provide Upstate New York with high-quality, compassionate care.	Cortland Regional Medical Center provides quality healthcare with skill and compassion, meeting the lifelong healthcare needs of all citizens, including Medicaid and uninsured populations, of Cortland and the

United Health Services Hospitals, Inc (PPS ID:44)

[United Health Services Hospitals, Inc] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			surrounding communities.
52	Cortland County Health Department	The Health Department that works to address community health needs throughout the county.	The Cortland County Health Department often services the needs of the Medicaid and uninsured populations by promoting health, preventing disease, injury, and disability while enhancing the quality of life within the community.
53	Access to Independence of Cortland County, Inc.	Access to Independence of Cortland County, Inc. is a not-for-profit organization. In 2001, ATI became one of New York State's 40 centers for independent living.	ATI aims to be a resource center for the provision of information and support services to people with disabilities, community, and organizations. ATI works to provide guidance and advocacy to people with disabilities in all areas that affect their choice to fully participate independently.
54	Seven Valleys Health Coalition	Seven Valleys Health Coalition, Inc. (SVHC) is a coalition of providers and interested individuals who play an active role in promoting effective, efficient and accessible health and human services to constituents in the service area.	SVHC cultivates local solutions and collaborative actions that advance the health and well-being of the Cortland community.
55	Cortland Park Rehabilitation and Nursing Center	Cortland Park Rehabilitation and Nursing Center has served the Finger Lakes district of Central New York for many years, providing the highest level of short and long term care.	Cortland Park provides the highest quality of individualized care to each resident in a manner that promotes dignity, comfort, and support - ultimately enabling them to reach their maximum level of physical, emotional, and psychosocial functioning and well-being.
56	Senior Lifestyle	Senior Lifestyle is a family-owned company that promotes healthy, happy residents through an unmatched level of service.	As a family-owned and operated company, Senior Lifestyle offers a level of attention, care, and compassion that is unmatched.
57	TLC EMS	TLC Emergency Medical Services Inc. operates emergency ambulance service in the City of Cortland and surrounding areas of Cortland County.	The Division Manger was interviewed to provide her perspective of experiences gained from managing the Cortland Division of an ambulance company. They provide 80% of Cortland County emergency ambulance services and are the primary ambulance provider for Cortland Regional Medical Center.
58	JM Murray	JM Murray is a diverse two-pronged service organization. The Services Division provides compassionate support services to individuals with developmental disabilities and their families. The Business Services Division offers contracted business services to various public and private organizations.	JM Murray offers people with disabilities the opportunity to obtain legitimate employment in a real world work environment while also teaching them valuable skills, improving their self-esteem, and enriching their lives.
59	The Central New York Area Health Education Center	The Central New York Area Health Education Center (CNYAHEC) is a non-profit health workforce development organization located in Cortland, New York. CNYAHEC's mission is to promote improvements in the supply, training, development and distribution of health professionals in a 14-county area of Central New York.	CNYAHEC, through collaborative efforts, improves access to quality health care by promoting improvements in the supply, training, development and distribution of health professionals in a 14-county area.

United Health Services Hospitals, Inc (PPS ID:44)

[United Health Services Hospitals, Inc] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
60	Karen Dudgeon, LCSW – Counselor, Cortland NY	"As a therapist, it is my job to provide a warm, safe and caring environment for clients to explore current difficulties and come up with ways of solving these issues using their strengths and creativity. I utilize a number of modalities including Cognitive Behavioral Techniques (CBT), stress reduction, and talk therapies to help clients discover and be their best self."	Dudgeon is committed to helping to make therapy accessible to those who want to make positive changes in their life.
61	Department of Family Services	Government organization that consists of two offices; The Office of Temporary & Disability Assistance, and The Office of Children and Family Services.	Presumably deals with the Medicaid and uninsured populations.
62	Cortland County Child Development - Daycare Program Inc.	The Cortland Child Development Centers provides child care for infants, toddlers and preschoolers. It also provides recreational care for school-aged children.	It provides a sliding tuition scale, unique to the make-up of each household.
63	Cortland County Mental Health Department	The Cortland County Mental Health Department offers a variety of programs and services such as prevention services for youth, a mental health clinic, the Horizon House, and family support services.	The Cortland County Mental Health Department aims to reduce the impact of mental illness and substance abuse by providing screening, assessment, and evidence based interventions to local residents with mental health conditions.
64	Delaware County	Government organization in that provides a broad array of services for residents to access.	Often communicates and services residents with Medicaid or those without insurance (e.g. Department of Social Services, Health Department, Mental Health, etc.).
65	Delaware County Alcohol and Drug Abuse Services	The Delaware County Alcohol and Drug Abuse Services is staffed with a team of professionally certified counselors and clinical workers. Treatment is available for adults, children, adolescents, and families.	Presumably deals with the Medicaid and uninsured populations.
66	Delaware County Community Services	The Delaware County Community Services is the local governmental unit created for policy making, planning, and management of the county's mental hygiene services.	Presumably deals with the Medicaid and uninsured populations.
67	Delaware County Office For The Aging	The Delaware County Office For The Aging is the agency responsibility for improving the quality of life for older Delaware County residents.	The agency is also responsible for the general well being of all elders regardless of gender, race, or income.
68	Schuyler Hospital	Schuyler Hospital is a 25-bed critical access hospital, with a 120-bed skilled nursing facility attached. Schuyler Hospital's main campus is located in Montour Falls, New York.	While the main hospital campus is located in Montour Falls, the system has evolved over the years into a network of providers, programs, and services that reaches throughout Schuyler County and into southern Yates and Seneca Counties to meet the healthcare needs of a population of over 32,000 residents including the Medicaid and uninsured.
69	Schuyler County	Government organization in that provides a broad array of services for residents to access.	Often communicates and services residents with Medicaid or those without insurance (e.g. Department of Social Services, Health Department, Mental Health, etc.).
70	My Place A Play and Learning Center	My Place provides affordable, dependable, quality	My Place participates with Child Care

United Health Services Hospitals, Inc (PPS ID:44)

[United Health Services Hospitals, Inc] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		child care that meets the identified community needs for child care, enabling parents to be/remain employed furthering the goal of self-sufficiency and job retention.	Subsidies provided by the Department of Social Services, and often services the needs of Medicaid recipients.
71	The Arc of Schuyler	The Arc of Schuyler is a family-based organization providing support to people with intellectual and developmental disabilities, including autism. The Arc of Schuyler is a chapter of NYSARC, Inc., which is the largest not for profit organization working with and for people with developmental disabilities in New York.	The Arc of Schuyler strives to create a community in which all people with intellectual and developmental disabilities are fully included as members of a community that embraces the diversity of all people, and values people for who they are in a safe and caring environment.
72	Arnot Health	Arnot Health is comprised of four health care centers; Arnot Ogden Medical Center, Ira Davenport Memorial Hospital, St. Joseph's Hospital, and Arnot Medical Services.	Arnot Health strives be recognized as the premier regional health care system delivering high-quality, safe, cost-effective, socially responsible health care services to all they serve, including Medicaid and uninsured patients.
73	Lowell Community Health Center	Lowell Community Health Center proudly provides access to high quality, affordable health care to children and adults of all ages -- regardless of their ability to pay. The Health Center has served the communities of greater Lowell since 1970 and has grown to include many specialty services in addition to comprehensive primary health care.	Lowell Community Health Center's mission is to provide caring, quality and culturally competent health services to the people of Greater Lowell, regardless of their financial status; to reduce health disparities and enhance the health of the Greater Lowell community; and to empower each individual to maximize their overall well being.
74	Watkins Glen Elementary Health Office	The Watkins Glen Elementary Health Office provides on-site healthcare services for students.	A Registered Nurse from the Elementary school was interviewed for her perspective regarding healthcare services in the region.
75	Parent to Parent of New York State	Parent to Parent of NYS, which began in 1994, is a statewide not for profit organization established to support and connect families of individuals with special needs. The 13 offices, located throughout NYS, are staffed by Regional Coordinators, who are parents or close relatives of individuals with special needs.	Staff field telephone calls from parents of children with disabilities and special health care needs who are looking for resources, services and information. Calls range from parents looking for information about medical services and therapies to looking for information specifically about an illness or disability.
76	Fazzary Eye Care	Fazzary Eye Care is a full service medical and optical optometry practice with state-of-the-art technology to examine and monitor eye disease, emergencies and vision problems.	Presumably deals with the Medicaid population.
77	Schuyler Ambulance	Provides emergency ambulance services to the residents of Schuyler county.	Presumably deals with the Medicaid and uninsured populations.
78	Schuyler County Office for the Aging	The Schuyler County Office for the Aging core function is provision of information / referrals and services for county residents age 60 and over, as well as their caregivers.	There is an emphasis on meeting the needs of the low income minority elderly population as well as those with disabilities.
79	Schuyler County Public Health Department	Schuyler County Public Health Department conducts the county-wide Community Health Assessment.	Presumably deals with the Medicaid and uninsured populations.
80	Schuyler Hospital's Seneca View Skilled Nursing Facility	Schuyler Hospital's Seneca View Skilled Nursing Facility has as 120 bed skilled nursing care facility.	The hospital offers short term rehab and the full range of hospital services due its location adjacent to Schuyler

United Health Services Hospitals, Inc (PPS ID:44)

[United Health Services Hospitals, Inc] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			Hospital.
81	Steuben County Public Health Department	Steuben County Public Health Department conducts the county-wide Community Health Assessment.	Presumably deals with the Medicaid and uninsured populations.
82	The YMCA of Corning	The YMCA of corning offers youth programs, swim lessons, health and wellness center, fitness classes.	The YMCA believes that positive, lasting personal and social change can only come about when we all work together to invest in kids, our health, and our neighbors.
83	Absolut Care	The Absolut Care family of long-term care facilities and professionals are dedicated to provide quality care with warmth and comfort.	Each facility offers skilled nursing care, but each care center has different strengths. From sub acute therapy, IV services, wound care, tracheostomy care, tube feedings, and as important being there for someone in their time of need are but a few of the services they offer.
84	Arbor Housing and Development	Arbor Housing and Development is a progressive, non-profit, corporation, committed to building independence and creating housing options to underserved populations primarily in the Southern Tier of New York and North Central Pennsylvania.	Arbor Housing and Development enhances the quality of life in communities by building independence and creating housing options.
85	Trillium Health	Trillium Health works to prevent the spread of HIV through education, prevention, and testing events.	Services include HIV/AIDS medical care, prevention, and support services, as well as medical care for HIV negative and LGBT communities.
86	United Way of the Southern Tier	United Way of the Southern Tier is a locally managed not-for-profit organization and the largest non-government funder of health and human services in Steuben and Chemung counties.	United Way of the Southern Tier provides funding for the 2-1-1 Helpline, FamilyWize Free Prescription Discount Program, and Community Care Centers.
87	St. James Mercy Hospital	St. James Mercy Health System is comprised of St. James Mercy Hospital, McAuley Manor at Mercycare long-term care facility, and various clinics throughout the rural service area. St. James Mercy Health System has provided health care services to residents in the Hornell area for over 100 years.	A Program Coordinator working under a NYS Dept of Health Grant with the hospital was interviewed regarding her experience with the breast cervical screening program for people who do not have insurance
88	The Cancer Services Program of Steuben County	The Cancer Services Program of Steuben County, under the lead agency of St. James Mercy Hospital, is a NYSDOH grant initiative that provides breast, cervical and colorectal cancer screening and treatment to men and women who are uninsured or underinsured. The grant also provides education, outreach and referral sources for cancer prevention and treatment.	The Cancer Services Program of Steuben County was chosen for participation in order to provide feedback regarding healthcare services provided to uninsured or underinsured.
89	Pathways, Inc.	Pathways, Inc. is a not-for-profit human service organization serving approximately 2,000 individuals and families in 12 counties in upstate New York. They provide an array of services through four core program areas including Residential Services, Community-Based Services, Educational Services, and Home and Habilitation Services.	Pathways, Inc. provides children, adults, and families with specialized programs and services in developmental disabilities, mental health, family support, traumatic brain injury, and child care.
90	Care First	CareFirst is a not-for-profit community-based program providing complete hospice, palliative care, and grief support services to residents of Chemung, Schuyler and Steuben counties of New York State.	Three interdisciplinary teams in Corning, Watkins Glen, and Bath provide individualized care to patients and their families, primarily in the home. The team works in

United Health Services Hospitals, Inc (PPS ID:44)

[United Health Services Hospitals, Inc] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			cooperation with the patient's personal physician to provide compassionate professional care and support for the patient and their families.
91	Corning Dental	Corning Dental prides itself on providing high quality dental care, with state-of the art technology in a gentle and comfortable environment.	Corning Dental prefers patients to pay for treatments, and then be reimbursed by their insurance company due to the confusion associated with dental insurance coverage. Interviewed for their perspectives working with Medicaid and/or uninsured.
92	Guthrie Corning Hospital	Guthrie Corning Hospital, one of the three hospitals in Guthrie's integrated system. It provides a wide range of inpatient and outpatient services with an integrated team of skilled and compassionate physicians, health care professionals, and staff.	Guthrie Corning Hospital is a not-for-profit health care organization. Its physicians and employees are focused on improving the health and well-being of the communities it serves. Potentially deals with Medicaid and uninsured patients.
93	Tioga County	Government organization in that provides a broad array of services for residents to access.	Often communicates and services residents with Medicaid or those without insurance (e.g. Public Health Department, Social Services, Mental Hygiene, etc.)
94	Southern Tier Independence Center	STIC is a not-for-profit, community-based advocacy and service organization for children and adults with all types of disabilities	STIC's mission is to shape a world in which people with disabilities are empowered to live fully integrated lives in their communities. They offer assistance, advocacy and services to children and adults with all disabilities.
95	Rehabilitation Support Services, Inc.	Rehabilitation Support Services, Inc. provides community-based mental health and substance abuse services to more than 3,000 individuals each year.	Rehabilitation Support Services, Inc. strives to enrich and empower the lives of individuals with severe psychiatric disabilities and substance use disorders by providing services and opportunities for meaningful emotional, social, vocational and educational growth.
96	Department of Family Services	Government organization that consists of two offices; The Office of Temporary & Disability Assistance, and The Office of Children and Family Services.	Often communicates and services residents with Medicaid or those without insurance.
97	Guthrie Clinic	Guthrie, located in north central Pennsylvania and south central New York, is a not-for-profit integrated health care delivery system that currently includes three hospitals, more than 450 physicians and mid-level providers, 29 regional provider offices in 23 communities, home health and home care services, and a research institute. Guthrie manages more than 1,000,000 patient visits a year.	A Reimbursement Coordinator was interviewed regarding her experience and perceptions of healthcare services in Tioga county.
98	Tioga County Public Health Department	The Tioga County Health Department is responsible for health promotion, disease prevention and community needs assessment.	The Public Health Department supports the citizens of Tioga County through Environmental Health, Dental Health, Disease Control, Nursing Services, Emergency Preparedness and Health Education Departments.

United Health Services Hospitals, Inc (PPS ID:44)

[United Health Services Hospitals, Inc] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
99	Tioga County Mental Hygiene Department	Tioga County Mental Hygiene Department protects and promotes the psychological wellbeing of the citizens of Tioga County.	Presumably deals with the Medicaid and uninsured populations.
100	Tioga Opportunities, Inc.	Tioga Opportunities, Inc. advances the self-sufficiency, well-being and growth of individuals, families and communities through human services, education, advocacy and resources.	Its goal is to ensure that all people receive the benefits available to them to enhance their lives. Presumably deals with the Medicaid and uninsured populations.
101	Northeast Pediatrics and Adolescent Medicine	Provides care from newborn to age 21 at two convenient locations in the Ithaca area in Tompkins County.	Feedback provided around Medicaid adolescents and children was needed for CNA.
102	Tompkins County	Government organization that provides a broad array of services for residents to access.	Often communicates and services residents with Medicaid or those without insurance (e.g. Office of the Aging, Emergency Response, Health Department, etc.)
103	Tompkins Learning Center	Tompkins Learning Partners is a not-for-profit organization that has been providing tutoring services, free of charge, to local residents who need help reading, writing, or speaking English.	This organization often services the Medicaid and uninsured populations who live or work in Tompkins County meet their personal goals, free of charge, by improving their ability to read, write, speak English, to use math, and computers.
104	Human Services Coalition of Tompkins County	HSC is part of a Statewide network of navigator agencies under the Community Service Society of New York. It runs three programs Human Service Planning, Health Planning Council, and the 2-1-1 Tompkins / Information and Referral.	HSC identifies information and services needs, to provide planning and coordination, and to enhance the delivery of health and human services in the Tompkins County area.
105	Cornell University	Cornell is a privately endowed research university and a partner of the State University of New York. As the federal land-grant institution in New York State to make contributions in all fields of knowledge in a manner that prioritizes public engagement to help improve the quality of life in New York state, the nation, the world.	Presumably deals with the Medicaid and uninsured populations.
106	Gannett Health Services - Cornell University	Gannett Health Services provides high-quality medical, counseling, and health promotion services that are designed to help patients get better in order to minimize disruptions and discomforts due to injury and illness.	Gannett Health Services is committed to providing high-quality services that are convenient, cost-effective, confidential, sensitive to the diverse needs of individuals, and responsive to the campus.
107	Cayuga Medical Center	Cayuga Medical Center believes that hospitals are shaped by the people they serve. Cayuga Medical Center houses 204 beds, employs over 1,200 health-care professionals, and has a medical staff of more than 200 affiliated physicians.	Cayuga Medical Center is a not-for-profit, acute-care medical center bringing state-of-the-art diagnostic and treatment services to the residents of Tompkins, Cortland, Seneca, and Tioga counties, including those on Medicaid and the uninsured.
108	Roman Catholic Diocese of Rochester	The Roman Catholic Diocese of Rochester is the visible presence of the, Catholic Church in this 12-county region in western New York.	The Department of Parish and Clergy Services provides services and programs for the offices of Vocation Awareness, Clergy Services, Deacon Personnel, Cultural Diversity, Pastoral Leadership, Interfaith Affairs, and Liturgy. It also oversees

United Health Services Hospitals, Inc (PPS ID:44)

[United Health Services Hospitals, Inc] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			ministries with jails, prison, healthcare, migrant workers, rural and urban areas.
109	Department of Family Services	Government organization that consists of two offices; The Office of Temporary & Disability Assistance, and The Office of Children and Family Services.	Often communicates and services residents with Medicaid or those without insurance.
110	The YMCA of Ithaca & Tompkins County	The YMCA is an inclusive organization of men, women and children joined together by a shared commitment to nurturing the potential of kids, promoting healthy living and fostering a sense of social responsibility.	The YMCA is committed to strengthening its community. Every day, they work side-by-side with neighbors to make sure that everyone, regardless of age, income or background, has the opportunity to learn, grow and thrive.
111	IthacaMed Community Centered Medicine	IthacaMed Community Centered Medicine provides primary care to adults, eighteen and older that reside in Ithaca and surrounding regions. In addition to endocrinology, they specialize in earliest diagnosis, preventative medicine, well woman, HIV, and psychological medicine.	IthacaMed Community Centered Medicine provides continuity of care for patients, providing follow-up care in the community, local hospital, local skilled nursing facilities and sheltered accommodation.
112	The Finger Lakes Independence Center	The Finger Lakes Independence Center is a voice of empowerment, agent for inclusion, and catalyst for change.	Empowers all people with disabilities while creating an inclusive society through the elimination of social and architectural barriers.
113	Foodnet Meals on Wheels	Foodnet Meals on Wheels provides a choice of one or two meals to more than 500 people daily.	Foodnet Meals on Wheels provides meals and other nutrition services that promote dignity, well being, and independence for older adults and other persons in need in Tompkins County.
114	Better Housing for Tompkins County	Better Housing for Tompkins County was incorporated as a not-for-profit organization to improve housing conditions in Tompkins County on behalf of low income, disadvantaged and minority residents of the community.	Better Housing for Tompkins County is dedicated to increasing sustainable, secure, and affordable housing options for rural residents in the county.
115	The Salvation Army	The Salvation Army has been supporting those in need in for 130 years in the United States. Nearly 30 million Americans receive assistance from The Salvation Army each year through the broadest array of social services.	The Salvation Army is a faith-based charity that helps people with all kinds of social needs in virtually every community across America.
116	Northeast Pediatrics and Adolescent Medicine	Northeast Pediatrics and Adolescent Medicine, specializes in caring for children. It provides patients with the quality service they deserve and expect.	Northeast Pediatrics and Adolescent Medicine provides pediatric medical care for children from birth to twelve years of age, and adolescent care from twelve to twenty-one years of age. In addition to seeing patients in offices, they care for newborns and children who need hospital care at Cayuga Medical Center at Ithaca.
117	Greater Ithaca Activities Center	The Greater Ithaca Activities Center is a center for all ages, particularly youth and teens. It serves the immediate neighborhood and the greater Ithaca area by providing multicultural, educational, and recreational programs focused on social and individual development.	The Center's programs include services dedicated to improving the quality of life for the people served; advocating for the rights and needs of youth, families, underrepresented and disenfranchised populations; providing structured employment training opportunities for at risk youth and adults; and fighting against

United Health Services Hospitals, Inc (PPS ID:44)

[United Health Services Hospitals, Inc] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			oppression and intimidation in the community.
118	Ithaca City School District	The school district offers educational services for PreK-12 in Tompkins county.	A school nurse was interviewed for her perspective regarding healthcare services in the region.
119	Beechtree Center for Rehabilitation and Nursing	Beechtree Center for Rehabilitation is a 120 bed skilled nursing residence and rehabilitation center located in the heart of the Finger Lakes in downtown Ithaca, New York.	Beechtree offers short term rehabilitation, long term care/skilled nursing, Alzheimer's/Dementia programs, and respite care.
120	Human Services Coalition of Tompkins County	The Human Services Coalition identifies information and service needs, to provide planning and coordination, and to enhance the delivery of health and human services in the Tompkins County area.	A Chronic Disease Project Coordinator was interviewed regarding experiences and perceptions gained from working on the Chronic Disease Project.
121	Visiting Nurse Service of Ithaca and Tompkins County	Visiting Nurse Service of Ithaca and Tompkins County, a non-profit community based home health care agency that delivers quality care to people of all ages.	Services provided include home health care, rehabilitation, tele-health, private duty care, long term home health care and patient referrals.
122	Child Development Council	Child Development Council promotes the healthy development of children and families at home, in child care, and in the community.	The Child Development Council provides programs for child care resources and referrals, family support services, and teen pregnancy/parenting programs.
123	Tompkins County Mental Health Department	Provides assessment, counseling, treatment, and crisis services to adults, children and families with mental health impairments, on a sliding scale basis.	Presumably deals with the Medicaid and uninsured populations dealing with mental health issues and crises.
124	Tompkins County Office for the Aging	Tompkins County Office for the Aging mission is to assist the senior population of Tompkins County to remain independent in their homes as long as is possible and appropriate, and with a decent quality of life and human dignity.	Presumably deals with ED visit scenarios for residents.
125	Franziska Racker Centers	Franziska Racker Centers is a voluntary not-for-profit dedicated to creating opportunities for people with special needs.	The Centers currently serves over 3,000 individuals and their families with approximately 200,000 individual services from their main service areas: Early Childhood, Clinical, Mental Health, Community Support, Residential and their Learning Initiative.
126	Ithaca Health Alliance	Ithaca Health Alliance has three primary programs: the Ithaca Free Clinic, the Ithaca Health Fund, and Community Health Education.	Ithaca Health Alliance facilitates access to health care for all, with a focus on the needs of the uninsured.
127	Kendal at Ithaca	Kendal at Ithaca is a not-for-profit continuing care retirement community.	Kendal at Ithaca provides independent living, assisted living, and skilled nursing facilities on the same campus to better serve the needs of residents as they age.

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.

New York State Department Of Health
Delivery System Reform Incentive Payment Project
DSRIP PPS Organizational Application

United Health Services Hospitals, Inc (PPS ID:44)

***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.

[United Health Services Hospitals, Inc] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
1	Increased mental health and substance abuse access	Those residents in need are seeking solutions for mental health and substance abuse conditions but running into barriers. Constituent groups indicated need for more providers, improved ability to get timely appointments, and the ability to see appropriate community based providers for appropriate condition(s). Healthcare utilization data for the STRIPPS geography indicates that there are 16,253 unique patients with BH and/or SA needs that have generated 27,733 ER visits and 7,079 impatient discharges.Shortage of Mental Health providers: 617:1 vs NYS of 510:1 Relates to project 4aiii: Strengthen Mental Health and Substance Abuse Infrastructure	In-depth interviews, Focus Groups, and an Online Survey. NYSDOH Salient Data, chartbooks
2	Access to transportation to receive healthcare	Constituencies indicated there were not enough transportation options and current options are unreliable and time consuming to seek out. This proves to be a significant barrier to access any non-ED options. Access to reliable and timely transportation resources is a critical preamble to the success of all of the designated STRIPPS project initiatives. Relates to All Projects.	In-depth interviews, Focus Groups, and an Online Survey.
3	Promotion of available healthcare service options beyond the ED, including community support organizations	Constituencies recognized that many ED visits were in fact inappropriate. Many users were unaware of other available healthcare options they could utilize at the time of need. There was low awareness of the 2-1-1 directory and various support organizations throughout the community. Organizations need to better work to promote their services throughout various channels including social media. NYS health department statistics indicate that approximately 60,000 unique patients within the STRIPPS service area that deal with a mental health/substance abuse and/or chronic condition. Relates to project 2ci: Development of Community Based Health Navigation Services Relates to project 2di: Patient Activation ("Project 11")	In-depth interviews, Focus Groups, and an Online Survey. NYSDOH Salient Data, chartbooks
4	Need more providers who accept Medicaid/uninsured patients to reduce improper ED usage	Research participants indicated that the supply of providers in the STRIPPS geography who accept Medicaid or accept those with no insurance is too small relative to the demand. This is particularly evident in key specialty, sub-specialty, and dental care service areas.	In-depth interviews, Focus Groups, and an Online Survey.

United Health Services Hospitals, Inc (PPS ID:44)

[United Health Services Hospitals, Inc] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		Relates to project 3ai: Integration of Behavioral Health and Primary Care Relates to project 3gi: Palliative Care in PCMH	
5	Affordable healthcare will promote Medicaid engagement	Medicaid recipients indicated that any out-of-pocket cost is a deterrent to accessing healthcare services. Furthermore, any point-of-service (POS) cost outlay at the time of care is a barrier for the patient (e.g., co-pays to seeking or receiving care). The healthcare audience and community leaders agreed Medicaid recipients and the uninsured abuse the ED to avoid POS out-of-pocket costs. Relates to project 2ci: Development of Community Based Health Navigation Services Relates to project 2di: Patient Activation ("Project 11")	In-depth interviews, Focus Groups, and an Online Survey.
6	Improved preventive care and wellness lifestyle and promotion	Medicaid recipients and those uninsured recognize the need to take ownership of one's health however they do not regularly engage in preventive care and/or wellness efforts. About two-thirds of Medicaid recipients and those uninsured see a PCP regularly, so the ability to discuss prevention and wellness options are limited for some but not most. Among those who see a PCP regularly, residents believe the PCPs need to better communicate preventative actions and discuss healthy lifestyle choices beyond solely treating the condition which warranted the patient's visit. Those with Medicaid and no insurance need to feel more accountable to be proactive with regard to healthy lifestyles. Relates to project 4bii: Chronic Disease Preventive Care and Management	In-depth interviews, Focus Groups, and an Online Survey.
7	Medicaid needs to improve its provider reimbursement system	The healthcare participants, community leaders, and Medicaid recipients were all aware of the current low reimbursement offerings to providers for Medicaid visits. Many recipients believed this notion impacts their quality of care. As a result, in some cases recipients believed providers would attempt to maximize revenue from each Medicaid patient per visit. Relates to project 2ai: Integrated Delivery System.	In-depth interviews, Focus Groups, and an Online Survey.
8	Medicaid recipients want extended provider visitation hours	Medicaid recipients stated that after-hours options for care were limited or unavailable particularly in rural counties. Among the STRIPPS geographies that offered after-hours care options, the hours were not extended enough. The fact that the ED offers 24/7 availability results in a consistently available option of choice for the Medicaid and uninsured population. The ED is a highly used source of care for the uninsured and Medicaid population in the STRIPPS PPS with over 36,461 unique recipients receiving care at an ER. Among those with a PCP, many still visit the ED outside of PCP office hours as needed or when they feel the wait time for an appointment is too long.	In-depth interviews, Focus Groups, and an Online Survey.NYSDOH Salient Data, chartbooks

United Health Services Hospitals, Inc (PPS ID:44)

[United Health Services Hospitals, Inc] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		Relates to project 2ai: Integrated Delivery System	
9	A need for delivery system integration and care coordination	All constituencies indicated that current healthcare is delivered in a silo model, very segregated. There needs to be more coordination and clinical integration across all healthcare entities to improve care and reduce redundancy. Constituencies indicated that mental healthcare needs to become entwined with traditional clinical care and blended more. Not all treatment needs to be cared for through a pharmalogical approach. Respondents desired a more holistic approach to treating patient conditions. Relates to project 3ai: Integration of Behavioral Health and Primary Care Relates to project 3aii: Crisis Stabilization Relates to project 4bii: Chronic Disease Preventive Care and Management	In-depth interviews, Focus Groups, and an Online Survey.
10	Improved provider-to-patient communication	Medicaid recipients and those with no insurance had a perception that their provider was aware of their insurance coverage status and as a result, this resulted in a perceived lower-level of care and less attention spent with the patient. Many Medicaid participants believed providers did not spend an appropriate amount of time communicating with them and were too quick to push prescriptions as a solution. Relates to project 3bi: Evidence-Based Strategies for Disease Management	In-depth interviews, Focus Groups, and an Online Survey.
11	Fix the loop-holes in Medicaid process to reduce unnecessary ED visits	Constituencies agreed that the Medicaid program as it exists today actually incentivizes recipients to receive care from the ED by removing any out-of-pocket costs. Relates to all projects in that it emphasizes a misalignment between appointments and high cost treatment.	In-depth interviews, Focus Groups, and an Online Survey.
12	Provide education around the appropriate setting for healthcare	Constituencies indicated that they believe the Medicaid and uninsured populations need to be told and coached as to the most appropriate setting for care. The Medicaid population needs to have reference resources that can teach and guide them where to receive the most appropriate care. Focus group participants described this as a "fast track" style system whereby patients are triaged and then are sent to the most appropriate setting for care. The PCMH model of care was well-received. Relates to project 2ci: Development of Community Based Health Navigation Services Relates to project 2di: Patient Activation ("Project 11") Relates to project 2ai: Integrated Delivery System	In-depth interviews, Focus Groups, and an Online Survey.
13	Provide education regarding quality of mid-level medical clinical providers	Many Medicaid recipients wanted to see a physician and were disappointed when they to visit a mid-level. Some felt they received lesser quality care. Rural residents were more understanding and	In-depth interviews, Focus Groups, and an Online Survey.

United Health Services Hospitals, Inc (PPS ID:44)

[United Health Services Hospitals, Inc] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		receptive to mid-level provider visits. Relates to project 2ci: Development of Community Based Health Navigation Services Relates to project 2ai: Integrated Delivery System	

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
44_SEC038_Section 3.Attachment 5.Chenango County CNA Resources.pdf	12/22/2014 07:24:50 AM	
44_SEC038_Section 3.Attachment 4 STRIPPS CNA Market Research.pdf	12/22/2014 07:21:59 AM	
44_SEC038_Section 3.Attachment 5.Broome County CNA Resources.pdf	12/22/2014 07:21:07 AM	
44_SEC038_Section 3.Attachment 5.Delaware County CNA Resources.pdf	12/22/2014 07:20:32 AM	
44_SEC038_Section 3.Attachment 5.Steuben County CNA Resource.pdf	12/22/2014 07:20:16 AM	
44_SEC038_Section 3.Attachment 5.Tioga County CNA Resources.pdf	12/22/2014 07:19:56 AM	
44_SEC038_Section 3.Attachment.5.Chemung County CNA Resources.pdf	12/22/2014 07:19:42 AM	
44_SEC038_Section3.Attachment 5.Tompkins Cortland Schuyler CNA Resources.pdf	12/22/2014 07:19:26 AM	

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

DSRIP PPS Organizational Application

United Health Services Hospitals, Inc (PPS ID:44)

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: **UHSH_Section4_Text_STRIPPS_DSRIP Project Plan Application _ Section 4 Part I FINAL 12.22.14.docx**

Description of File

File Uploaded By: bp442300

File Uploaded On: 12/22/2014 09:49 AM

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

Currently Uploaded File: **UHSH_Section4_ScopeAndScale_STRIPPS_Section 4_ Scale Speed.xlsx**

Description of File

File Uploaded By: bp442300

File Uploaded On: 12/22/2014 09:49 AM

United Health Services Hospitals, Inc (PPS ID:44)

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 workforce strategy was developed by the Workforce Development and Training Team (WDTT). Project implementation will have a minimal but wide-ranging impact on many of the 30,000 employees in the Region. Along with business-as-usual changes in staffing, new roles will be created and training will be needed for workers to support design changes intended to integrate service delivery in the Region. A reduction of about 135 in the acute care area and about 160 new opportunities in community based organizations is anticipated. Where the minimal staffing transitions are anticipated, the combined effects of redeployment, retraining and natural attrition will meet our strategy to avoid layoffs.

United Health Services Hospitals, Inc (PPS ID:44)

The WDTT identified four drivers of change: 1) productivity management; 2) the Projects. 3) process improvement and 4) turnover. The projections of workforce impact are estimates based on a preliminary review and will be adjusted following a comprehensive assessment. Plans to address the changes are to redeploy employees on a voluntary and "fit for role" basis, retrain employees that are identified to be displaced or redundant, train existing staff to accept new responsibilities or duties, and/ or assist staff who might wish to retire.

WDTT with the vendor will create a workforce strategy to ensure we have the right people, with the right skills, in the right place, at the right time, and the right cost. With a coalition of partners we will create a workforce future state template/model that balances specific supply and demand for staff and while supporting the overall Workforce strategy. The following considerations inform creation of a future workforce:
1.Redeployment/retraining of displaced staff are the first actions to rapidly create improved access to more community healthcare resources. We cannot redirect patients away from inpatient services to seek care in settings where resources are absent or scarce. These resources will also be critical so that as communications and marketing campaigns take hold, levels of access and service meet the expectations that we set for the population. This approach relies upon redeploying people with transferable skill sets or retraining the workforce from overstaffed areas and organizations. The number of people who may be redeployed or retrained is largely dependent upon the reduced demand for staff that will result from the reduced inpatient volumes and naturally occurring (e.g. retirements) staff reductions.
2. Recruiting/ hiring will be used to as needed where there is a shortfall of redeployed people to fill the new community based positions. 35 + RNs are needed to fully implement the Projects but preliminary calculations suggest only 20 will be displaced from acute care facilities. The approach for community based positions that do not have an acute care equivalent e.g. outreach workers and staff reductions fail to yield a large enough pool of people to be retrained.
Based upon an analysis of the Projects the following positions have been identified as potentially impacted in the Region.

1. Potential reductions in acute care due to a decrease need for in-patient and ER beds as a direct result of DSRIP will result in displacement of RN, nurses' aides and billing coders. Positions in other departments such as clerical, dieticians, LCSW are less directly linked to a reduction of revenue from one payer but could see reductions depending on the percent of MCD contribution to overall revenues in the facility.
2. Increase demand is primarily in the community setting and directly tied to the Projects. An increased need for patient navigators, community outreach workers, patient navigators and registered nurse is clearly needed to support Project implementation. As the Projects reach fully maturation an increase in other staff such as HIT, physicians and other health professions may become evident.

***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.

To counter these anticipated minimal staffing transitions related to DSRIP within the Region, we will engage the professional services available through current resources to design and implement training programs to meet the needs of those existing staff who may need retraining as well as provide training to new staff within the Region. The staff development departments within facilities, local colleges, AHEC, labor organizations training programs, and commercially packaged off the shelf programs will be utilized in the most cost effective and efficient manner. This approach will support a consistent and equitable approach to ensuring the maintenance of educational competency in the needed skill groups of existing and future staff members and assist workers who need additional training to redeploy to other roles.
Our research suggested that the following workforce shortages will have an impact on the PPS' goals for hospitals, nursing homes and home care agencies in our areas:
*Hospitals Top Difficulty in Recruitment:
Speech language pathologists
Occupational therapists
Physical therapists
Medical Coder
Pharmacist
Experienced RNs and Nurse Managers

*Nursing Homes Top Difficulty in Recruitment:

United Health Services Hospitals, Inc (PPS ID:44)

Experienced RNs
Physical therapists
Speech-language pathologists
Occupational therapy Assistants

*Community Based Agencies Top Difficulty in Recruitment:
Personal care aides
Speech-language pathologists
Licensed clinical social workers
Occupational therapists
Physical therapists

*Each list is in order of the most difficult to recruit for each sub group (Center for Healthcare Workforce Studies, School of Public Health, University at Albany, 2014)
Our research also indicated that with the emerging new categories of workers that will be needed such as care coordinators, patient navigators, and community health workers; we do not have reliable data that define each new position. These positions may vary based on the activities needed to implement each project. For example, care coordinators may be RNs, LPNs, bachelor's –prepared social workers or master's –prepared social workers (Center for Healthcare Workforce Studies, School of Public Health, University at Albany, 2014). The development of job descriptions that appropriately support project implementation and recruit persons with the correct skill set combined with careful calibration of wages and benefits to successfully recruit for newly created positions and/or entice workers to migrate from positions in an acute care setting to community based opportunities will be key to ensuring a workforce that meets the needs of the redesigned health care system.
Overall with all projects there will be an increase need for primary care physicians. In the Southern Tier there are 75 primary care physicians per 100,000 population in the Southern Tier region, which is below the state-wide rate of 84.5 (Center for Healthcare Workforce Studies, School of Public Health, University at Albany, 2014).
The ability to successfully implement the projects with the current number of providers can potentially be mitigated by increased use of advance practice practitioners, enhancing productivity through design changes (e.g. transferring activities that can be delegated to other workers), and improved care coordination to reduce the number of visits to providers.

***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	34%
Retrain	58%
New Hire	8%

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.

United Health Services Hospitals, Inc (PPS ID:44)

The WDTT recognized that the success of the projects selected to achieve CMS goals within the region are dependent on providing appropriate training for all workers to understand and support STRIPPS goals. The WDTT reviewed the Projects to assess training and workforce implications. The WDTT circulated their findings to the Projects Teams for further input on training and workforce implications. Preliminary work identifying reductions of workforce in acute care suggest personnel can be absorbed in new positions in the community. The challenge will be correctly aligning current workers with new openings.

Several levels of training were identified:
- Training for all health care workers that covers topics that inform workers about DSRIP, enhance cultural competency and understanding of health literacy issues, improve skills integrating electronic health records between providers and information about creating an integrated health delivery system and teambuilding.
- Redeployed workers will need training and orientation to new departments or new employers to align their skills with the new position. An example is an emergency room nurse who moves to ICU or a position in a Visiting Nursing Service.
- Training for persons hired into newly created positions. Care navigators, community outreach workers are examples of two key categories needed to several projects.
- Upgrading of skills and/or education for staff who have few or no skills for a new role or want to upgrade to a higher position. Examples are a displaced environmental services worker who wants to become a community outreach worker or a registered nurse who opts to become a nurse practitioner.

The WDTT identified organizations that currently provide training to health workers including the facilities staff development departments, SEIU Upstate Training fund, AHEC, community colleges and universities plus commercially available educational options. Training modalities such as on- the- job training, instructor led, web based, preceptor, college course, self-directed, etc. will be considered to maximize training resources and appropriately meet the training objective.

An appropriately training and deployed workforce is critical to achieving DSRIP goals. The WDTT opted to contract with a vendor to complete a comprehensive assessment of educational resources, training needs, conduct a gap analysis that will enable effectively address needs and allocation resources. Responsibility for implementation/coordination of a training plan will migrate from the WDTT to STRIPPS staff. The WDTT will be retained as an advisory body.

HR can identify departments with excess staff and use current workforce policies for notifying employees of vacancies within their organizations. Employees will be encouraged to volunteer. Absent volunteers, HR will identify employees for redeployment based on an assessment of employee's skill sets. Absent volunteers, in organizations where workers are covered by a collective bargaining agreement, the process outlined in the agreement for posting jobs, internal transfers, involuntary training and redeployment will be followed. HR can work with employees who volunteer or are targeted for transfer to assess training needs.
Vacancies in other organization may be posted and redeployed staff will be encouraged to apply. Attempts to minimize training needs will directly relate to an accurate assessment of a person skill set and how closely it aligns with the new position. Sometimes on-the-job orientation/ training may be sufficient to transfer an employee to a community based setting. The new employer will be responsible for such training. In instances where more extensive retraining is needed, STRIPPS will work with the impacted individual to identify training needs and resources for obtaining that training to enable the worker to accept a new role.

***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.

STRIPPS anticipates fewer staff employed within the acute hospitals and a higher demand in community based health care organizations. Wages and benefits historically are lower in the community settings. STRIPPS will track the success of recruitment efforts for new positions in the community to ensure wages/benefits are established at a level sufficient to attract the needed workforce. Wages and benefits may be impacted by retraining, refocusing, certification or other efforts to provide the necessary skill set to be redeployed to a different setting and/or role. STRIPPS will work with the Workforce Vendor to complete a gap analysis of current vs. needed workforce during development of the implementation plan. An employee volunteering or selected for redeployment will be referred to the appropriate HR department for detailed information to inform them about benefits, training opportunities, job description and other information they need to evaluate how the position compares to the position they are leaving. Ultimately, through attrition, downsizing organizations within STRIPPS anticipate few employees will involuntarily be required to seek employment in another organization.

United Health Services Hospitals, Inc (PPS ID:44)

***Retraining 3:**

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

STRIPPS is committed to ensuring that employees who want to participate will have a role and the necessary training to fulfill that role. Within health care organizations, displaced staff with the same titles or skill set may be asked to work in a different department or location. Staff will be informed of opportunities to work in other organizations. HR will direct employees to resources at SUNY Broome and TC3 to assist in identifying retraining options to help them transition if a different skill set is needed. After 90 days, employee refusal to engage in retraining/ redeployment will be managed consistent with a labor agreement if there is one and/or be deemed a voluntary termination. A terminated employee will receive terminal benefits as prescribed by the policies of the employer.

***Retraining 4:**

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

STRIPPS is working with labor representatives from SEIU, CSEA and NYSNA. Two other unions have a small presence in our region but declined invitations to participate. Labor representatives provided input into projected training needs of staff, staffing model and selection of a workforce vendor. Their input will be solicited as the vendor completes a comprehensive assessment of training currently available, organizations providing training (including labor organizations such as the SEIU Upstate Training Fund), and a gap analysis. During the implementation phase, labor representatives will have a role in delivering training, monitoring training activities and assessing the appropriateness of training provided for the workforce to meet new expectations resulting from displacement of individuals and/or changes in the design of health care delivery.

***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	37%
Partial Placement	63%

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.

Following successful implementation of the DSRIP projects, we anticipate a decrease in the staffing needs in Emergency Departments, Urgent Care Centers and inpatient acute care departments including Medical Surgical Units, Behavioral Services Units and potentially Intensive Care Units throughout The Region. In preparing this application the WDTT gathered data from STRIPPS participating hospitals to ascertain where positions are most likely to be affected over a 5 year period. A more comprehensive assessment will be conducted by the workforce vendor contracted to develop a comprehensive implementation plan. All members of the STRIPPS are committed to minimizing negative consequences to impacted employees and ultimately having the most qualified individuals filling newly created positions that are established as a result of projects implementation.
It will be the responsibility of the individual STRIPPS organizations to identify departments or functions that must reduce staff by utilizing their regular internal processes which minimally include a review of productivity, budget and census metrics. Identified categories of employees anticipated to be affected by the decreased acute care census are direct care providers including Hospital Aides and Registered Nurses. Where workforce reductions are necessary, ideally they would first be achieved through attrition. This is supported by findings by Healthcare Association of New York State's (HANYS) 2013 Nursing and Allied Health Care Professionals Workforce Survey Report indicating the average annual turnover rate for Registered Nurses in Central New York is approximately 14.9%. Secondly, identified employees and job functions that are affected and not balanced through attrition would be given consideration for positions which they are qualified for in their home institutions. Where applicable, an organization's collective bargaining agreement language which addresses job transfers and retraining will be followed. Each institution has established procedures which govern these situations. Therefore it is their responsibility for selection; retraining if necessary in these situations will be the responsibility of the institution as well.

United Health Services Hospitals, Inc (PPS ID:44)

When there are no internal vacancies these individuals will be given the opportunity to be considered for open vacancies and newly created positions which result from the implementation of the DSRIP projects. In order to help employees fully understand the potential redeployment opportunities, these individuals will receive job placement counseling to help them assess the requirements of the available openings vis-à-vis their education, experience and interests. Upon request, interested employees will be provided with a package which describes the available positions and related duties and responsibilities. Contact information for the appropriate organization's Human Resources Department will be provided. Representatives from Human Resources will also detail how a change in jobs will affect any post employment or terminal benefits that the employee may be entitled to.

***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.

In the Workforce Development implementation phase, members will consider options for establishing a central posting system for available positions that will support the redeployment efforts. The central posting system, operated by the PPS staff, will act as a clearing house to put redeployed workers in contact with potential partner employers within STRIPPS. Although they would not be guaranteed placement, redeployed staff would be given consideration for hire in comparison to other outside candidates. Ultimately the final hiring decision will be the responsibility of the supervising agency or organization. When an employee is redeployed to a new position, assistance will be provided for training in their new role. Attempts will be made to redeploy workers to positions that minimize any adverse impact to their wages and benefits and offer employees full credit for their past experience. All wages and benefits are commensurate with the new position and in accordance with the individual STRIPPS organization's pay structure and consistent with the provisions of any collective bargaining agreement.

***Redeployment 3:**

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

Employees whose positions are affected will not be assigned or automatically transferred to a redeployment opportunity. Employees will be encouraged to explore and apply for positions created by DSRIP. For a 90 day period, HR will facilitate employee access to career counseling services such as Tioga or Broome-Tioga Workforce NY to obtain career placement services such as assistance in assessing skill levels, aptitudes and job search/placement assistance. If however they choose not to pursue an available opening within the allotted amount of time as prescribed by their employer policies and practices they will be severed and considered to have terminated their employment. Whether or not they receive severance or terminal benefits will be determined by the policies of their employer.

***Redeployment 4:**

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

The concentration of organized labor in health care within the Region is not as great as other areas of New York. Most facilities where workers are represented will either not be impacted (e.g. County health departments) or have a potential to see an increase in positions (e.g. skilled nursing facilities). SEIU represents 582 employees in two acute care facilities where some potential to experience a need to redeploy workers exists. However, the WDTT recognizes the ripple effect of redeployment of one represented employee on other employees in a facility may multiply redeployments impact. Representatives of organized labor (NYSNA, CSEA, SEIU) were invited to be members of the WDTT however, only SEIU elected to send representatives to the WDTT meetings. Going forward the WDTT will engage labor representatives in the on-going conversations with and about their members who are identified for potential deployment or change in employment status. The STRIPPS organizations will continue to work with labor representatives to assure that all provisions of collective bargaining agreements are respected.

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.

United Health Services Hospitals, Inc (PPS ID:44)

The creation of a STRIPPS organizational entity and the implementation of DSRIP projects will create new opportunities. Some of these opportunities will augment existing shortages. For example, several areas in the region are HRSA for mental health (especially psychiatrists) so calls for more mental health providers of various levels add to the need for aggressive recruitment. As the PPS matures, the types and number of new hires will evolve. Preliminary estimates for the number and kinds of FTE for a fully mature PPS call for the need to hire approximately 160 FTE at many levels including:
Call center staff to support care transitions (4.5 FTE) Mental Health Providers (psychiatrist, psychologist, mental health therapists such as LCSW-C or psychiatric NP) – expand the availability of mental health services (17 FTE)
Advanced Practice Nurses – to supplement PCP or mental health providers and/or enhance assessment of patients in the community settings (7 FTE)
Registered nurse care managers – monitor and manage chronic diseases of patients to maintain health status (6 FTE)
Registered Nurses – to support the Care Transitions and Interact projects. (32 FTE)
Social workers or Registered Nurse to support Palliative Care Project (3 FTE)
Navigators – social workers with in depth knowledge of community resources to assist population to access services related to social determinants of health (22 FTE)
Licensed Clinical Social workers - to support strengthening the infrastructure for mental health and substance abuse (5 FTE)
Community outreach workers - engage Medicaid population through PAM. Skill set – community peers with knowledge of community and good communication skills (11 FTE)
Mobile crisis team – need one billable person e.g. LCSW and another person (6 FTE)
Trainers – this includes trainers specifically for PAM in Project 11, CDSMP Master trainers for the Cardiovascular project and a trainer for Palliative Care (12.5 FTE)
CDSMP peer leaders (8 FTE)
Administrative support for specific projects (4.5 FTE)
PPS staff when the PPS as an organizational entity is fully functioning. These include:
Executive Director (1 FTE)
Administrative Support (2-3 FTE)
Project management Office to lead project implementation activities. Skill set needed includes prior/current clinical experience and administrative experience (5 FTE)

Operations Office covering IT, provider relations, workforce and fund/ finance
Management. Professional skill sets based on specific tasking – IT, finance, etc. (7 FTE)
Population Health Office responsible for developing tools, monitoring and analyzing
information pertinent to managing population health Skill set data management and analytics (4 FTE)
Communications/Outreach Coordinator to oversee communications and outreach efforts
across STRIPPS Skill set – communications (1 FTE)
Regional Performance Unit advocates facilitating project implementation at a regional
level (specified amount allocated for stipend positions eventually awarded based
on performance) Probably coordinated through a health care provider with additional staff resourced as needed.
Primary care physicians (MD or DO) may be needed to expand the capacity to serve the non- or low utilizing Medicaid population and the uninsured. This will depend on factors such as expanded use of advanced practice nurses, enhanced efficiency and lower utilization of physician service resulting from improved care coordination, and patient adoption of preventive measures.

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
Mental Health Providers Case Managers	6
Social Workers	30
IT Staff	7
Nurse Practitioners	24
Other	92

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

DSRIP PPS Organizational Application

United Health Services Hospitals, Inc (PPS ID:44)

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	102,900	102,900	98,000	93,195	77,420	474,415
Redeployment	980	11,760	7,840	5,880	3,920	30,380
Recruiting	80,360	92,120	92,120	58,800	29,400	352,800
Other	3,760	4,220	4,040	3,125	2,260	17,405

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.

STRIPPS recognizes that there is a number of ever-evolving NYS and Federally funded programs that are designed to assist in the training, education, and retraining of healthcare workers. To track and take advantage of both existing and new programs, STRIPPS is working closely with our Workforce Investment Boards to identify programs, work through requirements, applications, responses and submissions for funds.

We have extensively researched existing available NYS programs for recruiting needs and funding sources for new hire training and retention of health care workers. While the Doctors Across New York (DANY) is not currently accepting applications, DANY, Primary Care Service Corp and other programs are being monitored for new rounds of funding. We will be making applications to the Health Workforce Retraining Initiative and the dislocated workers On-the-Job Training funds as soon as they are again available. Many of our STRIPPS members currently take advantage of new hire OJT funds as eligible associates are hired into their organization, which already assists with orientation and job training.

In addition, we will partner with other State entities to assist in delivering and executing our Workforce Strategy. STRIPPS will communicate continuing workforce needs to all providers and agencies for the purposes of recruiting youth and adults into the pipeline. STRIPPS will also utilize Health Workforce NY, social media based platforms, and all methods to communicate with partners. STRIPPS will utilize NY State workforce data to ensure the most comprehensive and accurate measures.

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 STRIPPS WDTT developed the preliminary workforce strategy. STRIPPS recognizes frontline workers must embrace system changes to effectuate the goals of DSRIP. STRIPPS has maintained openness/transparency with the PAC informing them of WDTT activities and soliciting input on workforce plans to implement DSRIP. The WDTT invited any PAC member interested in workforce development and training to join the team. Additionally, the WDTT sought other members for their expertise on training or workforce issues. To limits were placed on the number of team members. The 16 members represent hospitals (UHS, Lourdes, Cortland, Cayuga and Guthrie), Visiting Nursing Service of Ithaca, AHEC, SUNY Broom and TC3 community colleges, and SEIU. Further assistance was solicited from members of the Project Teams to guide considerations of a workforce strategy. As the WDTT moves into the development of a comprehensive workforce implementation plan, additional frontline workers will be engaged.

***Engagement 2:**

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

United Health Services Hospitals, Inc (PPS ID:44)

Engagement or workers occurred through the PAC with an open invitation to any workers interested in joining the WDTT. The WDTT initiated contact with the labor organizations active in the STRIPPS region including CSEA, CWA, NYSNA, PEF and SEIU. The unions were invite to participate in the PAC, select a representative for the PAC Executive Council and identify a representative to join the WDTT. PEF and CWA declined participation in STRIPPS. NYSNA represents 98 nurses - 17 working in a hospital aligned with the Finger Lakes PPS and 11 in school districts. The majority of the remaining members work in County Health Departments anticipated to be minimally impacted by DSRIP. CSEA represents workers in state agencies primarily at the state universities within the STRIPPS region. Other CSEA members work in OMH and OMRDD facilities experiencing downsizing unrelated to DSRIP. NYSNA and CSEA members are anticipated to be minimally impacted by DSRIP. SEIU, with members at two hospitals and several nursing homes, has a stronger presence but still fewer than 800 members. SEIU, NYSNA and CSEA named individuals for the PAC Executive Council. An SEIU representative is active on the WDTT.

***Engagement 3:**

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

The WDTT intends solicit involvement from a broader group of frontline workers to aide
in the planning and implementation of system change. In conjunction with the Communication Team, a minimum of monthly worker updates of PPS activities and opportunities for providing feedback will be developed. The geographic distances and availability of frontline workers (especially in small organizations) to attend WDTT meetings (either in-person or teleconference) is challenging. The WDTT will need to employ other techniques such as surveys, engagement through the internet, on-site visits, and town hall meetings to encourage feedback and input. This input is critical to implementing training and redeployment plans that meet workers needs and facilitate system redesign. As needed, ad hoc committees to address specific issues or facility specific concerns will be convened. Several mechanisms (survey, on-line feedback) will be used to assess the attitudes toward STRIPPS training, redeployments, recruitment and hiring efforts.

***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.

WDTT engaged the PAC to outline a plan to educate/engage target audiences that include providers, frontline and administrative workers and others. The Communication Team is developing a comprehensive plan for informing stakeholder/frontline workers about DSRIP. Messaging and timing of information release is sensitive to mitigating concerns that could raise frontline worker anxiety and undermine health care workers engagement in the projects. A variety of mediums (website, flyers, onsite visits, town meetings, etc.) and presenters (union representatives, PPS staff, employer, etc.) will provide an increasing level of detail. During monthly meetings and site specific and meetings, WDTT will engage more frontline workers in to review, monitor and addresses emergent issues related to the workforce changes. Successful use or WebX or teleconferencing, STRIPPS website and e-mails will continue to be used as tools for overcoming time and distance barriers to stakeholder/worker engagement.

Section 5.8 - Domain 1 Workforce Process Measures:

Description:

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

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

Please click here to acknowledge the milestones information above.

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

DSRIP PPS Organizational Application

United Health Services Hospitals, Inc (PPS ID:44)

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.

STRIPPS will perform centralized analysis and facilitate sharing of clinical information amongst participating providers while respecting patient privacy and all state and federal laws. Agreements between participants and STRIPPS will enable sharing of PHI with STRIPPS for measurement and analysis, while participation in and utilization of RHIOs will enable real-time access to clinical information.
Participation Agreements between each participant and STRIPPS define each party's responsibilities including data submission.
Business Associate Agreements (BAAs) that comply with state and federal standards define STRIPPS' data handling obligations as the business associate. Any organization STRIPPS utilizes in handling or analysis of PHI will be an associate of STRIPPS via a BAA.
RHIO Participation Agreements
Each STRIPPS participant will sign Participation Agreements with STRIPPS partner RHIOs. These agreements define RHIO patient consent requirement and appropriate access by participants

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

The STRIPPS IT Governance Committee oversees creation of and adherence to privacy policies and procedures. The IT Governance Committee seeks to enable productive use of data, while maintaining patient privacy by ensuring participants access only the minimum information necessary to fulfill STRIPPS' goals. The expectations of each STRIPPS participant are articulated in Participation Agreements.

Access to all Protected Health Information will be logged in compliance with HIPAA. Algorithmic and random audit techniques will be the basis of audits, in addition to audits at the request of any party. Any suspected breach or inappropriate use will be fully investigated by the Privacy Officer, reviewed by the IT Governance Committee, and reported to individuals, organizations, and state and federal agencies as appropriate. The Privacy Officer is responsible for administering the IT Committee's policies and will report the status or disposition of all investigations at each committee meeting.

***Confidentiality 3:**

United Health Services Hospitals, Inc (PPS ID:44)

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.

While the Participation Agreement and Business Associate Agreement structure alone will immediately facilitate centralized measurement and analysis by STRIPPS, it does not permit sharing of identified information between STRIPPS participants for clinical action. In order to share identified Protected Health Information between STRIPPS participants, informed consent of each patient is required. To that end, the STRIPPS will leverage the existing RHIO infrastructure and informed Consent process.

Each STRIPPS Participant will be required to participate with STRIPPS Partner RHIOs via the STRIPPS's RHIO Provider Organization Participation Agreement. Implementation of the Provider Organization Informed Consent will be required by July 2015 by all participants, and data submission for practices with RHIO supported EHRs will be required by January 2016. For STRIPPS participant types not able to submit to a RHIO (because of interface or EHRs limitations) a minimal data standard will be specified by STRIPPS. At each care transition or time interval specified by the STRIPPS, the participant will be required to submit data via a standard form sent by Direct Message or via a web based form. Data submitted via this form will be integrated into the RHIO alongside EMR data and available to PPS participants involved in each patient's care.

Partner RHIOs will compile informed consent from all PPS participants and enable the following activities for consented patients only:

- Real-time access to discharge summaries, lab values, radiology reports, and other EHR data submitted by participating organizations
- Hospital or Emergency Department admission notices to STRIPPS staff or participating providers, as directed by STRIPPS
- Analysis and measurement of clinical data for STRIPPS program specific measures and PPS-wide proxy measures for DSRIP outcomes
- Identification of gaps in care and reporting to STRIPPS staff and participating providers.

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 STRIPPS Operations Department is accountable for consistent measurement and analysis of results across all participants. The Operations Department is responsible to the Executive Director and reports PPS performance to the STRIPPS board and Clinical Governance Committee. Recommendations of the Operations Department, board, or Clinical Governance Committee are returned to the Project Management Office (PMO) and appropriate Regional Performing Units (RPUs). Each RPU is evaluated on the DSRIP measures of success used for the overall PPS.

As is more fully described in Sections 2 (Governance) and 5 (Workforce Strategy), the PMO has central project management responsibilities for each project to ensure consistency across regions, while RPUs are regional units of Participants with Care Management and Performance Improvement support staff. The RPU structure acknowledges and enhances existing regional collaboration patterns. Each RPU will distribute results to participants monthly and formulate individual action plans for improving performance.

The PMO and Each RPU are responsible to the Clinical Governance Committee, with day to day responsibility to the STRIPPS Executive Director.

***RCE 2:**

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

- Evaluate performance of PPS partners and providers

United Health Services Hospitals, Inc (PPS ID:44)

- Conduct quality assessment and improvement activities, and
- Conduct population-based activities to improve the health of the targeted population.

The Participation Agreement and BAA structure outlined in section 6.1 permits STRIPPS to centrally analyze clinical and administrative data immediately. Real time measures available from participant submitted data have been identified as proxies for the periodic DSRIP quality and utilization measures. These measures allow STRIPPS to evaluate partners and providers in year 1 and 2, and enable the Project Management Office and Regional Performance Units to drive rapid cycle performance improvement efforts. This initial data will also describe the population baseline (by disease and cohort) and inform targeting of population health efforts immediately.

As RHIO adoption and patient consent reach 80% of actively engaged patients in year 2, STRIPPS will transition to a population management system utilizing RHIO data.This system risk stratifies patients, facilitates patient identification and tracking for disease management, and provides real-time alerts to enable clinical interventions.

***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).

The Operations Department of STRIPPS is responsible for ensuring the integrity of analysis data, systems, and techniques, as well as overall PPS performance reporting on DSRIP utilization and quality measures to the STRIPPS Executive Director and Board. The project specific managers in the Project Management Office are responsible to the Executive Director and Board for result interpretation and analysis related to individual PPS projects.

The analysis and reports of the Operations Department and Project Management Office will be made directly available to STRIPPS participants via the PPS website . To ensure STRIPPS participants understand and act on this analysis, Regional Performance Unit (RPU) staff will be responsible for educating and communicating with providers and non-provider partners in their respective regions.

***RCE 4:**

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

Development of a highly integrated delivery system will require transformation of individual providers and the total system. The attempts of STRIPPS to formulate effective strategies to integrate patient care may not all be successful. The success of STRIPPS overall will therefore be driven by its ability to rapidly evaluate performance on specific initiatives and adjust strategy, operation, and tactics accordingly. As STRIPPS attacks specific care issues and general system coordination issues, it will need to carefully understand the performance in each area and simultaneously at the system level.

As the Project Management Office and the Regional Performance Units facilitate rapid cycle evaluation of each initiative, the Clinical Governance Committee and STRIPPS Board will monitor the success of the delivery system overall. The success of the delivery system will be evaluated by multiple DSRIP and STRIPPS measures of improvement in population health, quality, and cost (the Triple Aim

United Health Services Hospitals, Inc (PPS ID:44)

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 effectiveness of a health care delivery system relies on the ability to engage with individuals of all backgrounds and cultures. It is of great importance to be able to recognize and respond to individual patients in a culturally competent manner in order to elicit optimal outcomes.
The STRIPPS CNA and 2013 US Census Bureau data show our region's diversity, most notably with the following findings: a proportionally older population (over 15% versus less than 14% statewide); high rate of poverty (15.2% below the FPL); a geographically vast area (7,351.59 square miles arranged approximately 200 miles by 100 miles); and rural region with only four small metro counties. Despite lower ethnic diversity (92.8% white versus 70.9% state average), there are pockets of diversity such as 9.8% Asian and 4.6% Hispanic populations in Tompkins County. Chemung and Broome Counties show the highest percentages of Black/African Americans with 6.8% and 5.5% respectively. The region also has a higher proportion of disabled individuals with 13.5% compared to 10.9% statewide living in the community.
The Recommendations for National Standards and Outcomes-Focused Research Agenda point to a lack of understanding of patient's cultural and linguistic needs among both health care providers and organizations. STRIPPS will need to address health disparities related to our aging, wide-spread, and financially challenged population.
Three key challenges exist for STRIPPS to succeed as a culturally competent health care delivery system. First, as chronic conditions are more prevalent among the elderly, people of color, and those with disabilities, STRIPPS will need to address associated challenges in a culturally competent fashion. STRIPPS will also need to be sensitized to the cultural features of our aging, rural, and poor population.

United Health Services Hospitals, Inc (PPS ID:44)

Lastly, the rural nature of the PPS means that STRIPPS will need to attend to health care accessibility in a sensitive manner.

***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 implementation of a culturally competent health care delivery system will be of vital importance to ensure appropriate response to cultural competency challenges.
A measure of cultural competency will be assessed using the Nathan Kline Assessment Scale (NKAS). This scale is designed to establish a baseline and determine ways in which an organization can further develop cultural competence and help to identify training needs with respect to diversity and cultural competence. The NKAS will be administered utilizing various modalities which may include Survey Monkey, Staff Meetings, the STRIPPS website, etc.
Following assessment, the National Culturally and Linguistically Appropriate Services (CLAS) Standards will be used to monitor and react to evolving community cultural needs. The CLAS standards are intended to advance health equity, improve quality, and help eliminate healthcare disparities. Cultural knowledge gaps identified with the NKAS and changing population needs will be addressed in mandatory, standardized training coordinated at least annually through the STRIPPS WDTT. This training will incorporate healthcare-specific beliefs of different communities and religions and focus on diversity traits among the STRIPPS region. The entire workforce including STRIPPS Governance, leadership team, and healthcare frontline staff will be required to participate in this education.
The STRIPPS Communication Team will expand health care workers' cultural competence through the development of messages, monthly highlights, promotions, and other activities. Cultural competency and health literacy activities will be coordinated through a region-wide committee which includes frontline staff in various positions and disciplines throughout the area.
Policies and guidelines related to cultural competence will be also adopted by the STRIPPS governing body which will be held accountable for enforcing these practices. Workforce cultural sensitivity will be assessed annually.

***Competency 3:**

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

STRIPPS is fortunate to have some well-established resources in the region that have been open to facilitating cultural competency activities to support organizations throughout the region. In particular, Broome County Mental Health Department (BCMHD) has previously established cultural competence across the community including the Broome County Culturally Competent Committee (BCCCC) which has been in operation for over a decade. STRIPPS has reached out to BCCCC regarding the need to collaborate with this resource which is made up of community organizations, many of which are also PAC members and stakeholders such as Catholic Charities of Broome County, Mental Health Association of the Southern Tier, Community Options, SUDS treatment providers such as Fairview Recovery Services, etc. STRIPPS anticipates ongoing cooperation and involvement with these resources. This very experienced group has already been dealing with the demographics of the region and will be a resource for both identifying changing cultural gaps and new resources for addressing challenges. STRIPPS Cultural Competency Committee will collaborate with local experts such as the Broome County Culturally Competent Committee to help guide activities.
With these resources, Broome County has established a cultural competency blueprint that will be expanded and build on the other eight counties' cultural competency programs across the region.
Translation services are another potential contracting service that STRIPPS may need to establish if there are gaps in current facilities translation capabilities. Several modalities could be used for translation services including telephonic, video conferencing, and face-to-face. STRIPPS will utilize Language Identification Flashcards to assist with non-English speaking.
Other potential contracts that we may need to establish are experts to conduct the assessments, administer surveys, and provide uniquely tailored competency training.

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

United Health Services Hospitals, Inc (PPS ID:44)

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.

While the CNA discovered a large majority (93.1%) of individuals over the age of five speak only English in the region, this does not mean that there is an equal percentage of health literacy. Health literacy deals with the ability to interpret and comprehend verbal and written health information to allow for informed decision making. STRIPPS plans to implement the CLAS Standards to be responsive to the diverse communication needs, preferred languages, and health literacy of those in the PPS. Using the CLAS Standards, STRIPPS will continually assess and evaluate the health literacy level of the beneficiary population and the sensitivity of health care workers to health literacy issues. STRIPPS will implement practices to effectively connect culturally appropriate care with the recipient demographics to maximize levels of understanding and health literacy across the PPS. For example, non-English speaking patients can be linked to healthcare providers who are able to communicate in the patient's native language in order to promote and ensure patient comprehension.

Health Literacy will be acknowledged and integrated in the planning, development, and implementation phases of DSRIP projects. There are numerous resources available to assist in the creation of policies, procedures and development of materials, all with the aim of developing meaningful and lasting changes in provider sensitivity towards health literacy issues. This approach is not to improve patient ability in terms of literacy, but instead create a system that is health-literacy friendly and one that meets the recipients "where they're at" so they are capable of making appropriate and safe health care decisions. For example, a successful model that can be replicated is the Kansas City Care Clinic who adapted materials from plainlanguage.gov to create a Plain Language Checklist to verify if materials have been created in a health literate fashion. This checklist has questions related to clarity of purpose, ability to navigate, and proper tone and verbiage utilized in any written material.
All DSRIP projects will be organized and implemented with patient health literacy levels in mind and will utilize a checklist developed with guidance from plainlanguage.gov to verify the use of clear, plain language. This checklist will validate that simple language is used, ease of word flow, and will use pictures to assist with understanding whenever prudent. Existing programs and educational materials across the PPS will also be evaluated for health literacy appropriateness and adjusted as needed. Priority topics for the revision, creation and distribution of literacy-sensitive educational materials across the STRIPPS region will focus on areas of concern in tandem with the following selected DSRIP projects: Cardiovascular Disease, COPD, and Behavioral Health.
STRIPPS will establish culturally and linguistically appropriate goals, policies and management practices codified in the mission and structure of the PPS. STRIPPS will work with governance, leadership, providers and frontline health care staff to sensitize and offer health literacy education. This health literacy training program will be standardized across the PPS and monitored by the WDTT to promote a climate of awareness to the health literacy needs of the patient demographic in accordance with the established baseline of health literacy understanding. Advanced training will be offered and recommended for staff who struggle to grasp health literacy issues and concepts. This advanced training may include mock interviews and peer counseling.
Similar to the cultural competency approach for contracting with community based organizations, the STRIPPS workforce committee will coordinate with local resources such as the BCCC to provide monitoring and oversight which can be expanded to the entire nine county region.

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

United Health Services Hospitals, Inc (PPS ID:44)

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.

United Health Services Hospitals, Inc (PPS ID:44)

SECTION 8 – DSRIP BUDGET & FLOW OF FUNDS:

Section 8.0 – Project Budget:

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

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

Scoring Process:

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

Section 8.1 – High Level Budget and Flow of Funds:

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

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

THE STRIPPS funds distribution plan is organized into four categories: Costs related to Project Implementation and PPS Operations; Revenue Loss; Internal PPS Incentive or Performance Payments; Other: Contingency and Sustainability Reserves. The allocation of funds to these categories is based on the estimates of expense for each category and the proportion of expense each category represents in the total cost.
Project Implementation and PPS Operations expense is based on expense estimates for projects developed by STRIPPS project teams during preparation of the DSRIP application and the expenses associated with the staffing model for PPS operations. Revenue Loss was derived based on the estimated utilization impacts if DSRIP goals were achieved and the revenue value of those impacts. PPS Incentive /Performance payments were based on attributed lives and reserves were set at 5% of total funds.
The distribution of funds among the clinical providers occurs within two categories, Project Implementation /PPS Operations and performance payments. In the context of Project Implementation, specific provider services are required to implement and operate programs. In these instances, providers will be paid based on formulas that consider performance metrics and the number Medicaid beneficiaries and uninsured impacted as reflected in the projects scale and speed estimates. In the case where providers are expected to implement a fundamental program such as PCMH and need financial assistance, funding would be distributed based on the estimated Medicaid beneficiaries or uninsured to be served. In the context of PPS operations, there are provider roles in development of standards and performance assessment at the Regional Performance Unit (RPU) level. In these instances, a stipend payment would be established.
The distribution of funds for PPS operations, which are fixed costs, will be based on annual budgets. Distribution of funds for programs will initially be based on implementation budgets and will progressively convert to funding allocations based on achievement of project metrics in scale and speed.
The distribution of funds to providers for performance of incentive payments would be based on a payment methodology that incorporates STRIPPS overall performance, RPU performance and the individual provider's performance related to utilization quality metrics.
The distribution of funds ties to STRIPPS governance through the Clinical Performance and Finance Committees of the Board. The payment methodologies will be reviewed and recommended by the Finance Committee to the Board for approval. Payment in DSRIP is

United Health Services Hospitals, Inc (PPS ID:44)

based on performance which is defined, measured and reviewed by the Clinical Performance committee in conjunction with the RPUs. Performance results are applied to the approved payment methodologies and presented to the board for approval.
The overall approach is fully aligned with the achievement of DSRIP goals because it is calibrated to performance targets and magnitude of impact as measured by engagement of beneficiaries.

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	45%
2	Revenue Loss	44%
3	Internal PPS Provider Bonus Payments	6%
4	Contingency and Sustainability Reserves	5%
	Total Percentage:	100%

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

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

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

Please click here to acknowledge the milestones information above.

United Health Services Hospitals, Inc (PPS ID:44)

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.

STRIPPS focused its initial efforts on assessing the financial fragility of PPS partners that are fundamentally central in the early years of the PPS formation: hospitals, long term care providers and home health providers. In addition to the PPS Lead passing the required financial stability test, STRIPPS required each hospital to complete the same test and evaluated the pass/fail measures set forth in that test. For hospitals that did not meet every metric, STRIPPS discussed with the hospital its plans of remaining viable into the foreseeable future.

STRIPPS reviewed financial data for long term care providers aggregated by an industry vendor to assess financial stability. Given the uncertainty and historical inadequacy of state funding of Medicaid for long-term care, this market segment within the health care spectrum is seen as perpetually at risk.

Most of the Home Health providers in the 9-county area of STRIPPS do not meet the definition of safety net. Nevertheless Home Health providers are an important element of the health care spectrum serving Medicaid enrollees. STRIPPS requested and reviewed summary level historical data for each participating home health provider to assess financial viability. County owned and operated programs were automatically deemed viable.
The PPS also performed an initial estimate of the negative impact of DSRIP implementation on providers. This analysis was used as the basis for the sizing of the revenue loss category for funds distribution plan and testing the financial endurance of partner organizations.

United Health Services Hospitals, Inc (PPS ID:44)

It is the intent of the PPS to expand its assessment of financial stability to other providers within the PPS so as to identify financial fragile providers and the impact that DSRIP projects will have on their ability to provide services to the attributed lives.

***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.

The direct anticipated impacts from DSRIP are reductions in acute care utilization (inpatient avoidable admissions and ED visits) and the associated revenue, for all acute care providers in the STRIPPS network.These impacts are anticipated to vary based on the size of the Medicaid population served at any given facility and the overall size and financial health of the facility.These impacts will likely include short term issues with cash and cash flow. The magnitude of short term cash interruptions could be compounded by difficulties providers may have in adapting to the new business competencies needed to succeed with performance based payment specifically: capturing and organizing clinical data to track, guide process improvements and report on performance, care coordination, population health analytics, and the integration of quality and financial performance.
In addition, the reductions in utilization that result from DSRIP, along with the reductions in rate and utilization experienced with other payors, could create such significant financial challenges that providers will look to pruning services to achieve financial viability. However, given the financial dependencies within the service portfolio, any adjustment in services can serve to destabilize overall organizational performance.
Community based organizations (CBOs) may also have challenges. One set of challenges is centered on how these organizations have been funded historically. If the CBO has been reliant upon grant programs and special funding, they may not have the experience tor expertise to manage on a payment basis. CBOs may also have difficulty redefining their definition of success from clients served to a performance based outcomes and payment. Another set of challenges could emerge around growth and the need to scale up operations ahead of revenue.

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.

STRIPPS planning for financial sustainability in the transitioning reimbursement environment will be comprised of the following elements: maintaining an accurate understanding of the financial position of STRIPPS network providers; monitoring of the financial conditions in the local market;establishing sustainability funds; attracting needed capital funding,and; development and mastery of the core business competencies needed for financial success as the industry migrates to performance based payment.
STRIPPS partners have agreed to continuously monitor the financial viability of provider partners, collecting quarterly financial data and impact assessments from participating providers. Financial metrics will include liquidity, operating profitability and balance sheet stability areas. There are no known restructuring efforts at this time. It is expected that each provider partner will develop and submit restructuring plans if and when they are needed to remain viable.
Remaining financially viable alsorelies on each organization being vigilant and anticipatory of changes in the local environment and their overall organizational performance.
As a part of the overall financial planning for STRIPPS, a sustainability reserve will be funded to build working capital and contingencies reserves to assure the ability to function during short term disturbances in cash flow. In addition, the bylaws of STRIPPS provide a mechanism for requesting and approving capital requests from Corporate Members, STRIPPS also anticipates seeking a bank-offered line of credit as an additional source of interim working capital to bridge possible times of cash flow shortages
Attracting capital investment, including CRFP funds, are vitally important to connect provider EMRS and fills gaps in services. STRIPPS will support individual provider strategies for capital investment and develop overall STRIPPS strategies for capital funds for ongoing support of shared IDS functionality.
Key to long term sustainability is effectively transitioning the business model from fee-for- service to performance based payment approaches. The core competencies of that transition require a tight integration in the elements of financial and clinical performance.

United Health Services Hospitals, Inc (PPS ID:44)

***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.

Providers within STRIPPS are expected to be self-governing and to establish cost reduction strategies to mitigate as much of the impact as possible, created by the DSRIP program. STRIPPS, through the financial domain, will continue to monitor financial viability of its provider network using the financial stress test methodology, on an annual basis. Assuring a path to financial sustainability of providers essential to achieving the DSRIP goals involves each organization actively realigning its role and business model to succeed in a pay for performance environment. Through the IDS, STRIPPS will continue to provide critical shared services such as IT connectivity, care coordination, Population health analytics and a structure to manage clinical performance that will support PPS partners in adapting to new payment models. Revenue loss funding will be directed specifically to those providers who suffer revenue loss caused by DSRIP implementation.

***Path 3:**

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

Sustaining outcomes will rely upon STRIPPS demonstrating itself as a value added to the provider network in establishing and achieving clinical and financial performance targets. With the successful implementation and impact of the DSRRIP projects and the IDS, the providers in STRIPPS will be poised to sustain the programs and services that will benefit the patient population beyond the 5 year DSRIP period. They will also be well positioned to begin contracting with Medicaid Managed Care Organizations on programs that reinforce provider and patient roles in quality based population health management. The core competencies supporting STRIPPS ability to perform population health management will have been developed in the IDS and supported by the clinical performance management processes in the RPU and Clinical Performance Committee which are structural elements of STRIPPS governance.

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.

STRIPPS envisions a future payment system that is quality driven, objective, enables access to needed care, and incentivizes and rewards the coordination and delivery of efficient care. The vision for transforming to value based payment methodologies and engagement in managed care organizations lies in the successful implementation of the shared IDS functionality and the ability to manage clinical performance across the STRIPPs provider network.
Transitioning STRIPPS and its providers to value based payments will be achieved by building a clinical information foundation through the implementation of PCMH, EMR and IT connectivity, population health risk stratification and predicative analytics, care coordination services and telemedicine. These are the core competencies to be mastered during the five year DSRIP period. This foundation, operationalized through the RPUs and Clinical Performance Committee of the STRIPPS health care delivery model will prepare STRIPPS for effective dialog with managed care organizations (MCOs) around performance based payment approaches.
During the DSRIP program, STRIPPs will reach out to MCOs who are interested in working with STRIPPS on developing approaches to sustaining performance outcome achieved under DSRIP in a performance based payment environment.

***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 calls for achieving targeted patient outcomes with clinically appropriate cost effective care delivery. STRIPPS expects the DSRIP projects and the integrated delivery system network will reduce avoidable admissions and avoidable emergency department visits, thereby reducing the overall cost for a Medicaid episode of care.The initial reductions in income resulting from declines in utilization for some fragile providers will be compensated by DSRIP payments, and those payments will enable fragile providers to

United Health Services Hospitals, Inc (PPS ID:44)

reduce capacity and cost through realignment of programs and services within the STRIPPS network.
STRIPPS believes that shared savings arrangements will be the most productive methodology to achieve the goals of both DOH and providers. Shared savings models are more likely to drive a more efficient, effective and sustainable way forward. Full capitation models carry a level of risk that STRIPPS may not be able to handle as those models typically require large capital reserves. STRIPPS will be better positioned for value based payment models in which STRIPPS realizes shared savings for certain bundles of care. Such models, when applied in the STRIPPS framework, have the possibility of reducing redundant patient care costs and administrative costs, and sharing cost savings may be most beneficial to financially fragile safety net providers.

The operationalization of the IDS functionality will strengthen capacity in the CBOs and create the coordination of the delivery of care to achieve the targeted outcomes. Once the network is fully matured, performance based payments will be the best vehicles to optimize reimbursement to network providers and allow organizations to focus on patients and their outcomes to achieve financial stability.

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.

United Health Services Hospitals, Inc (PPS ID:44)

SECTION 10 – BONUS POINTS:

Section 10.0 – Bonus Points:

Description:
The questions in this section are not a required part of the application. However, responses to these questions will be used to award bonus points which will added to the overall scoring of the application.

Section 10.1 – PROVEN POPULATION HEALTH MANAGEMENT CAPABILITIES (PPHMC):

Proven Population Health Management Capabilities (PPHMC):
Population health management skill sets and capabilities will be a critical function of the PPS lead. If applicable, please outline the experience and proven population health management capabilities of the PPS Lead, particularly with the Medicaid population. Alternatively, please explain how the PPS has engaged key partners that possess proven population health management skill sets. This question is worth 3 additional bonus points to the 2.a.i project application score.

The STRIPPS lead organization is a Certified Medicaid Health Home (MHH). Since the spring of 2013 the UHS MHH has been focusing care management (CM) efforts towards providing quality care to highly acute mentally and medically ill Medicaid recipients.The program offers a patient-centered approach to improving medical, social, and behavioral health and well-being. The UHS MHH approach to CM is tailored to the individual needs of the patient with special attention to barriers to care commonly seen within the Medicaid demographic including housing, transportation, and treatment adherence. The UHS MHH shares with DSRIP both population health management objectives as well as an overarching goal (to reduce preventable ED visits and inpatient stays) and has demonstrated partner engagement through the establishment of Business Associate Agreements with multiple CM agencies in Broome County. These partners hold much expertise and knowledge about existing community services and have well-established programs serving the Medicaid population, making them valuable partners in DSRIP population health management initiatives.
STRIPPS also has noted experience with single signature network contracting through Cayuga Area Plan / Cayuga Area Preferred (CAP), the physician hospital organization in Tompkins County that represents Cayuga Medical Center and the Cayuga Area Physician's Alliance. CAP began integrated contracting in 2013 and has been functioning as an FTC-recognized clinically integrated network since 2009. STRIPPS will leverage CAP's experience with commercial payer contracting and clinical integration and apply this to the development of a STRIPPS IDS. CAP has a mature performance improvement methodology and tracks provider-specific quality metrics network-wide, awarding incentive payments based on performance. In 2014, 70% of CAP providers met incentive thresholds based pre-established quality indicators for population health management.

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.

An accurate and well reasoned workforce development plan will directly affect workforce engagement and impact the success of projects selected to achieve DSRIP goals. The initial intent is to contract with a vendor to assist in the development of the workforce implementation plan. Oversight of implementation of the plan is envisioned to be achieved through STRIPPS staff but consideration will be given to engaging a vendor during the implementation phase as needed. Proposals were received from two vendors - the Northern and Central New York Area Health Education Centers (AHEC) and the Iroquois Health Care Association. Both organizations have proven workforce experience with recruitment, retention and training spanning more than ten years. Both have established relationships with health care organizations which can be leveraged. The proposals were carefully reviewed by the WDTT. Priorities for evaluating a vendor included selection of a vendor with familiarity with the Region, a solid grasp of the Projects and experience developing strategic workforce plans. The WDTT reviewed the vendors' articulation of services they would provide for comprehensiveness and assessed how well the proposal reflected a collaborative approach to working with WDTT during the development of the workforce implementation plan. The Northern and Central AHEC was selected as the workforce vendor. The process of formalizing a contract has been initiated. STRIPPS intends to finalize the contract as soon as possible with a target of December 31, 2014.

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

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

DSRIP PPS Organizational Application

United Health Services Hospitals, Inc (PPS ID:44)

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 United Health Services Hospitals, Inc that all information provided on this Project Plan Applicant is true and accurate to the best of my knowledge.***

Primary Lead Provider Name: UNITED HEALTH SERV HOSP INC
Secondary Lead Provider Name:

Lead Representative:	Robin Marie Kinslow-Evans
Submission Date:	12/22/2014 12:41 PM

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