New York Department of Health Delivery System Reform Incentive Payment (DSRIP) Program

DSRIP Support Team ***Prototype*** Application

November 14, 2014

***NOTE:* this prototype response is a hypothetical example only and should be read alongside the official application documents. Throughout this document, our prototype responses are highlighted in yellow.**

Section 1 – Executive Summary

(Pass/Fail with No Scoring)

Scoring Process	Pass/Fail. 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.

Description

The PPS & Project Plan Application must include an executive summary clearly articulating how the PPS will evolve into a highly effective integrated delivery system. The executive summary should address the following:

- Succinctly explain the identified goals and objectives of the PPS;

PPS Response (Limited to 275 words or less)

The following specific objectives underpin this vision and reflect the needs identified in our CNA and the milestones and metrics for our domain 2 and 3 DSRIP projects:

- Improve the coordination of care through stronger networks between providers – particularly primary care, behavioral health and community care – and create robust processes and protocols for collaboration, referral and handovers
- Improve disease management and crisis prevention, particularly for those with chronic and behavioral conditions, through targeted outreach for specific populations
- Take a more pro-active approach to population health management and engaging with at-risk individuals, supported by comprehensive patient registries and effective use of IT and data sharing, including between medical and behavioral health services
- Create a clinically interoperable data system (based on our existing HealthInsight system) that allows rapid information sharing between providers
- Decrease the costs of accessing healthcare (both time and money) that are barriers to effective use of preventive and disease management services.
- Improve access and provide more 'one-stop shop' experiences for patients through increased co-location of services (including the creation of a medical village) and by bolstering the infrastructure of primary and community facilities (including the creation of a number of 'premium APCs').
- Pro-actively prevent non-emergency care being delivered in the ER (including through the co-location of primary care services in the ER)
- Identify and reach out to those groups that currently rely on emergency care (including the uninsured) and support them in accessing services more effectively;
- Shift the focus of our providers, from providing inputs to delivering outcomes, through value-based contracts and payment structures

- Transform our participating providers into a highly efficient Integrated Delivery System by the end of the DSRIP Program

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

PPS Response (Limited to 150 words or less)
In structuring the PPS, we have created governance and leadership structures that ensure transparency and regular communication. We have opted for a delegated governance model to allow for efficient decision making and the ability to allow multiple partners to have a strong influence in the future development of the PPS. In order to retain strong community representation, transparency and communication, we will retain and empower our PAC, whose monthly meetings will be attended by the entire Executive Body.

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

PPS Response (Limited to 150 words or less)
Our strategic vision is the transition from a disparate system of providers focused on isolated parts of the continuum of care, to a coordinated system of health and care, in which providers collaborate to meet the (health and social) needs of the patient proactively. Care will be delivered upstream and in a community / primary setting rather than a hospital setting. This vision will be underpinned by rapid and comprehensive data sharing between providers and pro-active population health management (using our Health Homes' existing infrastructure as a starting point). Simultaneously, we will work with our MCOs to shift rapidly towards value-based payments throughout the system to ensure the long-term viability of the changes we will implement. The resulting reduction in required inpatient capacity will require the restructuring of the financially challenged Poplar Hospital Medical Center into a community hospital with only outpatient facilities.

Scoring Process	Pass/Fail. 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.

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

(Please see *Regulatory Flexibility Guidance for Performing Provider Systems*, available at: http://www.health.ny.gov/health_care/medicaid/redesign/docs/reg_flex_guidance.pdf).

(Please mark the appropriate box below)

Yes	No
	X

If 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 Response

PPS' should be aware that the agencies may, in 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.

Section 2 – Governance

(25% of the Overall PPS Structure Score)

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.

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 PPS.

Governance Organizational Structure

Please provide a narrative that explains the organizational structure of the PPS. In the response, please address the following:

- 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 why the selected organizational structure will be critical to the success of the PPS. In addition, please attach a copy of the organizational chart of the PPS. ***Also, please reference the "Governance How to Guide" prepared by the DSRIP Support Team for helpful guidance on governance structural options the PPS should consider.***

PPS Response (Limited to 500 Words)
The Forestland Health Provider Partnership (FHPP) is a PPS formed under the New York State DSRIP Program that intends to begin operations under a Delegated Governance structure. This decision was reached after several months of meetings and discussion among the members of the Project Advisory Committee (PAC), Forestland Hospital Center (the initial Lead Applicant), the Forestland Department of Health and Mental Hygiene (FDHMH), and potential vendors. There were a number of critical considerations for the choice of the Delegated Governance Model, chief of which is the large number (180) of FHPP partners with highly variable capabilities that are involved in FHPP. The Delegated Model will provide a more efficient implementation structure to manage the large number of Partners and enable FHPP to meet the goals of DSRIP. An additional consideration for the Governance Model was the number of organizations that elected to engage as vendors to FHPP, rather than as Partners. By establishing the FHPP Project Management Office (PMO) as an LLC, we will be able to manage these vendor relationships more efficiently and

effectively while reducing some of the ongoing management burden and risk to Forestland Hospital Center (FHC).
The Delegated Model allows for shared control by the two other Capital Contributing Partners (Greater Forestland Methodist Hospital and Blackbark Medical and Mental Health Center), who each own 25% of the LLC, and non-Capital Partners from all components of the care delivery system.
Finally, the Committee Chairs were selected based on the projects that were derived from the CNA.
While the Delegated Governance Model was chosen to improve the efficiency of decision-making, the representative nature of FHPP has not been lost. FHPP has achieved the critical balance between efficient governance and transparent representation.

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

PPS Response (Limited to 500 Words)

The initial step in building the Governance Model for FHPP began with discussions regarding the composition of the Executive Body – the governance component into which the other governance functions report. The PAC Governance Working Group (described below), concluded that the best structure for the Executive Body should be a combination of functional representatives (traditional delivery system functions) and stakeholder representatives (based on the needs of the community).
The result is a nine member Executive Body with the following members:

- 1 Non-acute or Nursing Facility member
- 1 Physician member
- 1 Behavioral Health member
- 1 Acute Facility member
- The 5 Committee Chairs

In addition to providing direction and oversight, the Executive Body has some specific responsibilities in the FHPP governance structure, including:

- Monitor the performance of FHPP, including all Committees, Partners, and vendors
- Approve all Charters, Policies and Procedures
- Generate reports to DOH as needed
- Approve all contracts and agreements
- Develop the Operating Agreement
- Develop the dispute resolution process

Reporting to the Executive Body are the five Committees that will do the work of governance.
The Committees of FHPP were developed expressly to support the projects that were selected as part of the application. These projects directly address the community's needs as per the CNA, as well as the other fundamental requirements of the DSRIP Program (Finance and Compliance).

Two of the Committees have already been populated in order to support the further development of FHPP. The first of these is the Financial Governance Committee, which has already begun work to document the distribution of DSRIP funds so that there is no delay when the funds become available. The Compliance Committee has been established so that FHPP maintains strict adherence to DSRIP guidelines and other pertinent laws and regulations as the PPS is developed. The first task of this Committee is to produce a working draft for a compliance program in accordance with NY State Social Security Law 363-d. Going forward, the Compliance Committee will review and approve all contracts and agreements.

The remaining three Committees – IT/Data, Community Initiatives, Clinical Governance - will be formed and populated by April 1, 2015 out of the current Project Application Plan work groups. These three Committees will be responsible for continuing the cooperation with the other 3 PPAs that resulted in all four PPSs selecting the same 11 projects. Specifically, the Committees will work in cooperation with the other PPSs to:

- Develop a single data sharing & exchange infrastructure for the region
- Develop a common set of performance metrics for the projects
- Coordinate patient and community outreach and communication

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

PPS Response (Limited to 250 Words)

The Clinical Governance Committee (CGC) has the largest role relative to the Projects. Its work will be divided into four Sub-Committees:

- The Emergency Department Sub-Committee - project 3 (Triage for at-risk populations)
- The Behavioral health Sub-Committee - projects 5, 6 and 9 (Integration of primary and behavioral health, community crisis stabilization services, mental health and substance abuse infrastructure)
- The Primary Care Integration Sub-Committee - projects 2, 4 and 10 (co-located primary care services, care transitions intervention, increase access)
- The Population Health Management Sub-Committee - projects 7 and 8 (evidence-based strategies for diabetes and cardiovascular disease)

Although much of the work and discussion will be done in the Sub-Committees, the approval of clinical pathways, quality standards and clinical measures will require the agreement of the entire CGC. In addition, the CGC will develop the organizational processes to ensure accountability at the PPS level for the clinical DSRIP outcomes, including the overall monthly scorecard for the Executive Body. Finally, this committee will work with the Financial Governance committee to develop recommendations for pay-for-performance initiatives.

Given the strategic and transformational importance of Project 1 (Creating an Integrated Delivery System), a dedicated Workgroup will be responsible for this Project. This Workgroup reports directly to the Executive Body.
Having the Executive Body composed of functional representatives (nursing facility, physician, behavioral health, hospital) and the Chairs of the five Committees assures that the members of the PPS will be optimally aligned to achieving the goals of FHPP.

- When 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.

PPS Response (Limited to 250 Words)

Although FHPP believes that the Governance Model described above provides the best beginning for FHPP, there is general acknowledgment that FHPP operational and governance structure may need to evolve as FHPP gains experience as a multi-partner inpatient care reorganization, payment reform starts to be implemented, and as the health care environment changes. FHPP believes that any decision to alter governance must be based on current or expected future performance. As such, the Executive Body will monitor the progress of FHPP monthly. If performance is not acceptable for any reason, an internal review process, described in more detail later, will ensue, the result of which may be a change in governance structure. Any recommendation for a change in governance structure will be discussed in the PAC before being brought to the attention of DOH.

Scoring Process	This response ***is worth 20%*** of the total points available for *Section 2 – Governance*. The response will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.

Governance Members and Governing Processes

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

- 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.

PPS Response (Limited to 150 Words)

Governance Element	Member Name	Function	Role
Executive Body	Prince CharmingCEO	FHC	Majority Owner Rep and Chair
Executive Body	Sneezy	VP or higher	NF Rep
Executive Body	Doc	Practicing physician	Physician Rep

Executive Body	Happy	Practicing provider	Behavioral Health Rep
Executive Body	Grumpy	Legal Counsel	Compliance Chair
Executive Body	Dopey	CFO	Finance Chair
Executive Body	Bashful	CIO	IT/Data Chair
Executive Body	Sleepy	CMO	Clinical Chair
Executive Body	Snow White	Not specified	Community Chair
PAC	Leia	Not specified	Chair
BH	Luke	Department Head	Chair
ED	Han Solo	Department Head	Chair
PHM	Yoda	Department Head	Chair

The GNWG is continuing to work with the FHPP leadership and Committee Chairs to populate all Committees and Sub-Committees. The Governance Nominating Working Group is expected to remain nominally active throughout the DSRIP Program as there may be a need for new Committees and a need to replace positions that become vacant.

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

PPS Response (Limited to 500 Words)

Shortly after we submitted our Letter of Intent, a "Governance Working Group" of 15 Partners was established to begin deliberations on the governance structure for FHPP. In keeping with the representative nature of FHPP, the Governance Working Group (GWG) was chaired by the Lead Entity representative, but included representatives from all key areas including CBOs and a patient representative. The GWG has been meeting every two weeks and has received input from legal counsel, specialized consultants, and others. The GWG has presented a formal report to the PAC at each monthly meeting.

In the September meeting of the PAC, the GWG presented its final recommendation for FHPP governance structure. After due consideration, the recommendation was adopted by the PAC on voice vote.

Upon adoption of the governance structure recommendation, the GWG disbanded. At the same time, a new working group, the Governance Nominating Working Group (GNWG), was established to identify and recommend individuals to serve in the various governance positions. The single exception is that the initial Lead Entity, FHC (now the 50% owner), retained the right to appoint the Chair of the Executive Body, which is also the Acute Facility representative. The two other Capital Partners retain the right to appoint the Chairs of the Financial and the Clinical Committees, respectively.

The initial charge to the GNWG was to present a slate of candidates for the other Executive Body seats and the Chairs of the Committees. Interested parties submitted a statement of interest and

qualification to the GNWG. From this list, the GNWG solicited a small number of individuals to serve based on their expertise.
The slate of candidates was presented to the monthly PAC meeting in October 2014 and candidates were selected by simple majority on a ballot vote.

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

PPS Response (Limited to 125 Words)

All providers and organizations in the FHPP service area have been invited to participate since the beginning of the process of forming the PPS. The initial vehicle was the PAC, which was operating in an open and democratic manner. As the governance structure developed, representation was balanced between system function, capital partners, non-capital governing partners, and vendors. Each participant was given the opportunity to self-select their final role in FHPP. The role of the community is focused on the Community Initiatives Committee, which reports into the Executive Body.

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

PPS Response (Limited to 125 Words)

The FHPP partners are included in two areas. The Capital Partners are most directly involved through their leading role within the Project Management Office, where they will direct the management of the PPS.

In regard to governance, the Capital Partners are included by way of the Chair of the Executive Body and the voting rules, which give each Capital Partner effective veto power (see below).

Other FHPP partners are included through the representative nature of the governance structure and the on-going advisory role of the PAC. Although many of the roles on the committees and sub-committees are voluntary, the GNWG has worked diligently to establish broad and representative participation without impacting the content expertise required.

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

PPS Response (Limited to 225 Words)
In addition to selecting the FHPP leadership at the October meeting, the FHPP PAC endorsed a set of Guiding Principles for Decision Making. These Principles include guidance for communication, stakeholder engagement and voting. Regarding voting, our Guiding Principles state: 1. Each work group, committee and body will have an odd number of members 2. A quorum consists of a simple majority of the members 3. Decisions are made with a simple majority vote of the members in attendance except where designated to require a super-majority vote 4. Issues requiring a super-majority vote (super-majority is defined as 60% of the total members of the body): a. Addition or deletion of projects b. Allocation of funds c. Initiation of disciplinary process of a partner 5. Unresolved issues are escalated to the Executive Body An additional Guiding Principle for voting within the Executive Body states that, any decision approved by the Executive Body must have the support of all three Capital Partners.

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

PPS Response (Limited to 125 Words)
The governing body and committees have been structured to minimize conflict through composition (always having an odd number of members) and process (our Guiding Principles and voting process). In the event of unresolved conflict at the committee level, issues are escalated to the Executive Body for deliberation. If needed, issues can be brought to the PAC for broader discussion among all participants. Failing resolution at the Executive Body, with or without in out from the PAC, issues are escalated to FHC as the Lead Entity and fiduciary for FHPP. As a final step, FHC is prepared to consult DOH or other regulatory bodies.

- Describe how the PPS governing body will ensure a transparent governing process, such as methodology in which the governing body will transmit the outcomes of meetings.

PPS Response (Limited to 125 Words)
The principles for communication state that all meetings will produce detailed minutes that include the names of those in attendance and all business that was conducted. The minutes are to be posted on the FHPP on-line bulletin board within 10 working days. Only the Executive Body is allowed to go into closed session. It is expected that all Partners are entitled to attend all and any meetings except the closed sessions of the Executive Body, even though they may not be able to vote. Further reinforcing the representative character of FHPP is the requirement that all members of the Executive Body are to attend monthly PAC meetings in order to allow for regular two-way communication with the PAC.

- Describe how the PPS governing body will engage stakeholders, including Medicaid members, on key and critical topics pertaining to the PPS over the life of the DSRIP program.

PPS Response (Limited to 125 Words)
Communication and transparency are the basis for stakeholder engagement. These Principles are supported through the representative composition of all governance elements and the frequent open meetings, such as the monthly PAC meetings and semi-annual "all hands" meetings. Further, the meetings of the PAC and the Community Initiatives Committee are open to the public as the intended forum for the inclusion of all members of the FHPP community. Engagement of Medicaid beneficiaries is furthered through the Community Initiatives Committee, one of whose voting members must be a Medicaid beneficiary.

Scoring Process	This response ***is worth 30%*** of the total points available for *Section 2 – Governance*. The response will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.

The Project Advisory Committee (PAC)
Describe the formation of the project advisory committee of the PPS. In the response, please address the following:

- Describe how the PAC was formed, the timing in which it was formed, along with its membership.

PPS Response (Limited to 300 Words)
FHPP operates in a densely populated urban setting, which is responsible for some important characteristics that influenced the development of the governance structure. There are three important regional considerations that influenced the development of the governance structure:

- The large number of Partners (180) and vendors (346) that need to be considered in the governance process
- The FHPP service area has the highest number of Medicaid and uninsured patients in NY State
- The FHPP service area overlaps with the services areas of 4 other PPSs.

Taken together, these three characteristics combine to create a high degree of organizational complexity. Recognizing the need to manage this degree of complexity, FHPP began forming its PAC early. The initial announcement of the intent to form a PPS was made in March 2013 and the initial meeting of the PAC was in April 2014.

As noted above, the formation of the PAC began with the public announcement in April 2014 by FHC of the intent to participate in the DSRIP Program. The notice was placed in all major publications, was the subject of an extensive Public Service Announcement, and was posted on the FHC web site.

The PAC meetings began that same month. In keeping with the theme of transparency, all initial meetings were open to the public. Eight separate educational PAC meetings were held in between April and June 2014, all facilitated by an outside consultant.

The meetings of the newly formed PAC began the week of July 1st, 2014.

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

PPS Response (Limited to 125 Words)

At the first meeting of the PAC, two work groups were established to begin to lay the foundation for FHPP – the Governance Work Group and the Community Needs Assessment Work Group (CNAWG). The GWG is responsible for the governance section of this Application. GWG and PAC members are cognizant that the PAC will retain responsibility for communication to FHPP stakeholders throughout the duration of DSRIP. Further, it is understood that the PAC will transition from a decision-making body into an advisory body commensurate with the beginning of DSRIP funding on April 1, 2015.

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

PPS Response (Limited to 125 Words)

In the mid June meeting of the PAC, those in attendance confirmed the concept of two groups of FHPP participants – Partners and vendors. It was understood that only Partners would vote in the PAC meetings and only Partners would continue as part of the governance structure after April 1, 2015. Equipped with the knowledge of the responsibilities of becoming a FHPP Partner, it was decided that all organizations that intended to seek Partner status were required to submit an initial attestation of participation before June 26, 2014.

The CNAWG was responsible for the completion of the Community Needs Assessment and the recommendation of the 11 Projects. Having completed its Charter, the CNAWG is now disbanded.

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

PPS Response (Limited to 125 Words)
[Our prototype response was drafted in response to the 29th September version of the application. This bullet point was added after that version, as a response to public comment. Our prototype does not, therefore, include a response to this bullet.]

Scoring Process	This response ***is worth 15%*** of the total points available for *Section 2 – Governance*. The response will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.

Compliance

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:

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

PPS Response (Limited to 125 Words)
Upon recommendation of FHC General Counsel and after approval by the PAC, Sally Joe Samuel will be hired by the Project Management Office as FHPP's Compliance Officer. Ms. Samuel has no ties to any FHPP Partner, but brings considerable experience within New York State through her previous experience in the Buffalo area. Ms. Samuel will begin her new role with FHPP on January 1st, 2015.

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

PPS Response (Limited to 150 Words)
The following principles have been established: • The Compliance Officer is an employee of the LLC works in the FHPP PMO • The Compliance Officer will attend all meetings of the Executive Body and PMO management • The Compliance Officer will Chair the Compliance Committee, which will be a standing committee of the Executive Body • The Executive Body and the Compliance officer will jointly agree upon the DSRIP, State and Federal rules and regulations that will be included in this oversight role.

- All agreements, contracts, policies and procedures require review by the Compliance Committee prior to execution

It is the responsibility of the Compliance Officer to review the Hot Line and report the contents and actions taken to the Executive Body on a monthly basis.

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

PPS Response (Limited to 150 Words)
As a part of completing the FHPP Compliance Plan, Ms. Samuel is responsible for developing Compliance education and training, including a PPS-wide HIPAA program, and establishing audit procedures and schedules, all of which is expected to be rolled out between April 1 and July 1, 2015 after Ms. Samuel completes the inventory of existing compliance training programs of the partners. Ms. Samuel will have the option of adopting one of the existing programs or designing new programs tailored to DSRIP. The compliance education and training program is expected to provide information both on the definition of compliance and how compliance irregularities can be reported.

- 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.

PPS Response (Limited to 125 Words)
[Our prototype response was drafted in response to the 29th September version of the application. This bullet point was added after that version, as a response to public comment. Our prototype does not, therefore, include a response to this bullet.]

Scoring Process	This response ***is worth 10%*** of the total points available for *Section 2 – Governance*. The response will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.

PPS Financial Organizational Structure

Please provide a narrative on the planned financial structure for the PPS including a description of the financial controls that will be established. This narrative should include, at a minimum:

- 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.

PPS Response (Limited to 150 Words)
The specific tasks for the Finance Committee include: • Develop and approve policies and procedures for funds flow • Implement mechanisms for financial accountability and oversight • Bring exceptions/questions to the Executive Body • Escalate issues to the attention of the Executive Body when they exceed the budget guidelines by 5% • Monitor financial performance of FHPP and all Partners and report to the Executive Body monthly • Work with the Clinical Governance Committee and area Health Plans to develop recommendations for specific pay-for-performance initiatives, including bundled payment and capitation arrangements

- Description of the key finance functions to be established within the PPS.

PPS Response (Limited to 150 Words)
The financial structure for FHPP has three components: • The FHPP LLC • The Finance Committee • The Project Management Office As the fiduciary to DOH, the FHPP LLC will be receiving and distributing DSRIP funds beginning on April 1, 2015. The Finance Committee has principle oversight of all financial matters for FHPP. Currently the Chair and members of the Finance Committee are working with the Executive Body to finalize the financial policies and procedures to be used by FHPP. It is expected that the initial documentation will be complete by January 31, 2015. Among the issues to be addressed are: • Spending authority limits for the Committees and the PMO • Completing the description of DSRIP fund distribution • Developing the annual budget process, especially for the PMO • Defining the financial metrics that Partner organizations are expected to meet • Completing the financial compliance program in conjunction with the Compliance Committee

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

PPS Response (Limited to 150 Words)
Discussions are also underway with the FHPP Compliance Committee to determine if a single audit firm can meet the needs of both financial and general compliance. When complete, the financial compliance program will meet all requirements of New York State Social Services Law 363-d.

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

PPS Response (Limited to 150 Words)
The first draft of the compliance program has been completed by the Compliance Committee. The Compliance Committee and Finance Committee are meeting in a joint work group in order to have a revised working draft to be delivered to the Compliance Officer (CO) on January 1, 2015. The CO is charged to complete the program design by March 3, 2015.

Scoring Process	This response ***is worth 10%*** of the total points available for *Section 2 – Governance*. The response will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.

Oversight and Member Removal

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

- Describe the process in which the PPS will monitor performance.

PPS Response (Limited to 150 Words)
FHPP believes that good governance provides organizational performance oversight through data-driven measures. The development of the PPS-specific metrics has been assigned to the Finance, Clinical and IT/Data Governance Committees. Additional metrics will be developed as FHPP gains experience and expertise in the DSRIP Program. FHPP will use its PPS-specific Performance Measurement Portal, which will be made available to the PPS through the MAPP, for the monitoring of its performance on the claims-based, non-Hospital CAHPS DSRIP metrics, as well as the DSRIP population health metrics. We will develop our own PPS-wide Performance Measurement system for the Medical Record-based measures, as well as any additional measures we generate ourselves. The target performance goals will be included in the contracts with all Partners and vendors, which will describe the expected minimum level of performance of the individual Partner/vendor required to meet overall PPS targets.

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

PPS Response (Limited to 150 Words)
On a monthly basis, all Committees will supply reports to the Executive Body that will include those Partners and vendors that are approaching the minimum level of performance. Poorly performing Partners will be subject to a comprehensive evaluation process.

- Describe the process for the 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.

PPS Response (Limited to 300 Words)
If poorly performing partners are identified, the Executive Body will schedule a closed executive session within 14 calendar days. The Partner will be informed of the date of the executive session, the reason for the executive session and will be invited to attend the meeting. In the interim, the Partner will be offered consultation with any Committee Chair and members of the Executive Body. Following the executive session the Partner has 30 calendar days to submit a Plan of Action to address the performance issue(s), which must include monthly reporting to the Executive Body. Within 14 calendar days of the submission of the Plan of Action, the Executive Committee will convene a closed executive session to consider the Plan. If the Executive Body finds the Plan of Action to be acceptable, the Plan will be initiated. If the Executive Body finds that the Plan of Action is not acceptable, the Partner has another 30 days to resubmit the Plan. At any time after 90 days of objective below-minimum performance, the Executive Body can prepare a Statement of Recommendation to Dismiss to be presented to a combined meeting of the Lead Entity, the Executive Body and DOH. FHPP recognizes that the DSRIP programs spans five years and that impacts of DSRIP will extend well beyond that time. From that recognition FHPP will establish a process to add additional Partners. Unlike the initial process of Partner selection, which was voluntary and democratic, any organization seeking to join, or re-join, FHPP must complete an assessment process that will be presided over by the Executive Body.

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

PPS Response (Limited to 125 Words)
[Our prototype response was drafted in response to the 29th September version of the application. This bullet point was added after that version, as a response to public comment. Our prototype does not, therefore, include a response to this bullet.]

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

PPS Response (Limited to 125 Words)
[Our prototype response was drafted in response to the 29th September version of the application. This bullet point was added after that version, as a response to public comment. Our prototype does not, therefore, include a response to this bullet.]

Scoring Process	This response ***is worth 15%*** of the total points available for *Section 2 – Governance*. The response will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.

Domain 1 - Governance Milestones

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 that 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 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 policy and procedures documenting the formal development of governance processes or other documentation requested by the Independent Assessor.

Section 3 – Community Needs Assessment
(25% of the Overall PPS Structure Score)

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.

Description
All successful DSRIP projects will be derived from a comprehensive community needs assessment (CNA). Since DSRIP is about system transformation, the structure of a DSRIP CNA will be different from the usual public health format. The CNA should be a comprehensive assessment of the health care resources and community based service resources currently available in the service area and the demographics and health needs of the population to be served. This will lead to the identification of excesses and gaps in services that will need to be corrected in order to transform the system to one that meets the goals of DSRIP. The CNA will be evaluated based upon the PPS' comprehensive and data-driven understanding of its service delivery system and 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 and how the choice of projects combine to result in the envisioned transformed system. The CNA shall be properly researched and sourced, shall effectively incorporate the stakeholder engagement in its formation, and shall identify current community resources, including community based organizations, as well as existing assets that will be enhanced or eliminated as a result of the PPS' CNA. Lastly, the CNA should include documentation, as necessary, to support the PPS' community engagement methodology, outreach and decision-making process.

For more information on DOH's expectations to ensure a successful completion of the CNA, please refer to the document, *Guidance for Conducting Community Needs Assessment required for DSRIP Planning Grants and Final Project Plan Applications*, and the DSRIP Population Health Assessment Webinars, Part 1 and, particularly 2, located on the DSRIP Community Needs Assessment page:
http://www.health.ny.gov/health_care/medicaid/redesign/dsrip_community_needs_assessment.htm

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 how the health care delivery system functions, the community the PPS seeks to serve and the key populations where service gaps are identified. 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 be done with consideration that future community assessments will be required. DOH has provided a significant amount of relevant data that should inform and be leveraged to complete the CNA process. This data, in addition to other relevant data sources produced other state agencies, can be found on the DSRIP Performance Data, found here:
https://www.health.ny.gov/health_care/medicaid/redesign/dsrip_performance_data/.

It is critical that the PPS leverage the data sources available on the DSRIP Performance Data page to ensure the successful completion of the CNA.

Overview on the Completion of the CNA
Please describe the completion of the CNA process and include in the response the following:

- Describe the process and methodology in which the CNA was completed.

PPS Response (Limited to 250 Words)
Forestland's CNA was developed over the course of three months, from July 22nd to October 23rd, by the Woodland Academy of Medicine (WAM) and supported by Forestland Health. All sections of the CNA were created in accordance with the Guidance for Conducting Community Needs Assessments document provided by DOH as well as the checklist provided by the DSRIP Support Team. After a robust and thorough data collection period conducted by WAM using both primary and secondary data sources the information and its insights were compiled into a CNA document. The first draft was circulated end of September to guide the project decision making. Approximately 600 resident surveys were completed by Forestland residents aged 18 and older. Survey questions focused on demographics, health concerns, healthcare utilization, barriers to care, and the use of community services. Respondents were recruited from a variety of areas and demographic groups to create a complete and accurate picture of Forestland today. Surveys were administered by WAM staff or volunteers and translated into 10 languages to reflect Forestland's diverse population. In addition to surveys, 20 key informant interviews and 5 focus groups were also conducted to gather deep insights into the main health concerns and gaps in care experienced in Forestland. Key informants and focus group members were selected based on having specific health expertise, or to represent particular groups (LGBTQ) or issues (substance abuse, homelessness). Also, opinions were gathered as to how the DSRIP program could create maximum positive impact for their specific needs and concerns.

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

PPS Response (Limited to 250 Words)
The secondary data analysis closely followed the recommendations and guidelines set forth in the Guidance document, and highlighted the specific challenges of our region's Medicaid population and its care delivery system. The analysis began with publically available data to assess healthcare and community resources, disease prevalence, demographic characteristics, current rates of (avoidable) hospital (re)admissions and ER visits, other available quality performance information (such as PQI and CAHPS scores) and social determinants of health. The aim of this component of study was to assess preventable emergency room visits and hospitalizations. WAM's analysis of public data was supplemented with a review of available literature, including reports prepared by participating providers, DOH, Greater Forestland (GFL) departments of health and city

planning, and others. Advanced techniques, such as regression analysis, were used to explore relationships between relevant variables to discover key population health data.
The key data sets that informed the CNA process include the following: NYS Community Health Indicator Reports, Behavioral Risk Factor Surveillance Systems (BRFSS), the Statewide Planning and Research Cooperative dataset (SPARCS), Work- and Chartbooks, datasets and dashboards available at the DSRIP Performance Data website, GFLDOHMH HIV Surveillance Systems, GFLDOHMH Community Health Surveys, and various other health care resources and community based resources.
In addition to robust secondary data analysis, primary data was also collected and analyzed to ensure that the perspective of community members and stakeholders was incorporated into the reported findings and to respond to specific questions that could not be sufficiently addressed through secondary source data alone.

Scoring Process	This response ***is worth 5%*** of the total points available for *Section 3 – Community Needs Assessment*. The response will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.

For the following sections, please reference the Guidance document for additional details to ensure completeness.

Healthcare Provider Infrastructure
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. These resources should include but are not limited to the following:

- Hospitals;
- Ambulatory surgical centers;
- Urgent care centers;
- Health Homes;
- Federally qualified health centers;
- Primary care providers including private, clinics, hospital based including residency programs;
- Specialty medical providers including private, clinics, hospital based including residency programs;
- Dental providers including public and private;
- Rehabilitative services including physical therapy, occupational therapy, and speech therapy, inpatient and community based;
- Behavioral health resources including all mental health and substance use disorder treatment providers (including future 1915i providers);
- Specialty medical programs such as eating disorders program, autism spectrum early;
- Diagnosis/early intervention;
- Skilled nursing homes, assisted living facilities;

- Home care services;
- Laboratory and radiology services including home care and community access;
- Specialty developmental disability services;
- Specialty services providers such as vision care and DME;
- Pharmacies;
- Local Health Departments;
- Managed care organizations;
- Foster Children Agencies; and
- Area Health Education Centers (AHECs).

Please address the following in the response:

- Describe in an aggregate level the existing healthcare infrastructure and environment, including the *number and types of healthcare providers* available to the PPS to serve the needs of the community.

PPS Response (Limited to 400 Words)
There are currently 14 major hospitals providing acute care services across the whole of Forestland, with 3 hospitals involved in the Forestland PPS. These 3 hospitals have bed capacities ranging from 134 to 711 beds. Of these hospitals, Rosewood Medical Center and Poplar Hospital Center treat the largest proportions of Medicaid and uninsured populations, driven in part by their geographic locations in East Forestland. The larger (two-site) Forestland Hospital Center supports the communities further west. There are currently 16 ambulatory surgery centers, 21 urgent care centers, and 103 office based surgical practices in Forestland, highly concentrated in higher socioeconomic status neighborhoods. There are 70 PCMH-certified providers in Forestland, of which only 12 have achieved their 2014 Level 3 PCMH certification. The rest are underdeveloped, lacking the communication and care coordination infrastructure necessary to provide improved care to Forestland's Medicaid beneficiary populations. There are 4 DOH designated Health Homes in Forestland, 2 of which are part of Forestland PPS. There are 19 FQHCs and 319 diagnostic and treatment centers. There are 79.5 FTE primary care physicians per 100,000 people in Forestland, less than the NYS average (84.5 per 100,000). This average of 79.5 varies wildly according to zip codes, and is severely lacking in lower income areas of Forestland. There are 54 dental clinics in Forestland, located primarily in Northern/Central Forestland, Birchview, and Cedar Bay. Behavioral health is a key issue in Forestland's healthcare resource composition. Forestland has 21.1 psychiatrists and 192.7 social workers per 100,000 people, which is dramatically lower than the GFL rates of 49 and 231 respectively. There are 186 mental health residential programs in Forestland, ranging from inpatient mental health clinics to weekly substance abuse support programs. Stigma about accessing mental health services tends to result in patients accessing services late, rather than accessing preventive or early treatment. There are 42 nursing home facilities with a total bed capacity of 10,246 scattered evenly throughout the county, with the exception of Maple Hill, Willow Flatlands and Birchview. The Forestland Department of Health and Mental Hygiene is the local health department for Forestland. DOHMH has a District Public Health Office located in Forestland, designed to serve high-need areas of the county. In addition to the population health projects of DOHMH in the county, the

Forestland DPHO also focuses on two major population health initiatives: maternal and infant health and promoting physical activity and good nutrition.

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

PPS Response (Limited to 400 Words)
Current efforts to restructure some hospitals in Forestland have led to concerns that, with closures, remaining hospitals will receive an influx of patients that will overload the system. The hospital systems in Forestland recognize that potential future capacity issues can be fixed by taking actions today to improve care integration and reduce preventable readmissions. The composition of providers in Forestland is currently too focused on acute care, reflected by the large numbers of independent hospitals, with large overlap of specialized service offerings (acute cancer care, for example, is provided by 13 of the 14 hospitals). The three hospitals in Forestland PPS provide good emergency coverage across the East and Central parts of Forestland, although the ER infrastructure at Poplar Medical Center is more limited and under strain. Ambulatory care services are noticeably absent in zip codes with higher proportions of Medicaid beneficiaries and uninsured. The primary issue with Forestland health homes is that only 40% list weekend operating hours, and only 55% list any evening hours, yet many Medicaid beneficiaries who rely on these services work during other hours of the day. In addition to geographic access being poor for dental care, there are strong financial barriers to dental care due to the cost of treatment. As well as geographic variation, hours of access is a key issue for primary care, especially in neighborhoods where crime is common, where evening and weekend services are not common.. The three main challenges stemming from the provider landscape in Forestland are: firstly, inadequate distribution of healthcare resources, with many specialized services skewed towards areas of higher socioeconomic status, rather than the areas of greatest need; second, there is an overemphasis on acute care in Forestland's provider landscape, with insufficient focus on chronic care management and behavioral health; and lastly, the healthcare resources in Forestland are severely fragmented, making care transitions and care integration difficult for patients, particularly those with multiple morbidities

Scoring Process	This response ***is worth 15%*** of the total points available for *Section 3 – Community Needs Assessment*. The response will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.

Community Resources Supporting PPS Approach

Community based resources take many forms. This wide spectrum will include those that provide 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. These resources should include but not limited to the following:

- Housing services for the homeless population including advocacy groups as well as housing providers;
- Food banks, community gardens, farmer's markets;
- Clothing, furniture banks;
- Specialty educational programs for special needs children (children with intellectual or developmental disabilities or behavioral challenges);
- Community outreach agencies;
- Transportation services;
- Religious service organizations;
- Not for profit health and welfare agencies;
- Specialty community-based and clinical services for individuals with intellectual or developmental disabilities;
- Peer and Family Mental Health Advocacy Organizations;
- Self-advocacy and family support organizations and programs for individuals with disabilities;
- Youth development programs;
- Libraries with open access computers;
- Community service organizations;
- Education;
- Local public health programs;
- Local governmental social service programs;
- Community based health education programs including for health professions/students;
- Family Support and training;
- NAMI;
- Individual Employment Support Services;
- Peer Supports (Recovery Coaches);
- Alternatives to Incarceration;
- Ryan White Programs, and
- HIV Prevention/Outreach and Social Service Programs.

Please address the following in the response:

- Describe in an aggregate level the existing community resources, including the *number and types of resources* available to the PPS to serve the needs of the community.

PPS Response (Limited to 400 Words)
There are 256 food banks in Forestland, made up of food pantries and soup kitchens, as well as 86 community gardens and 65 farmers markets. Many of these gardens and markets are clustered in northern and central Forestland, and there are concerns that individuals in low-income neighborhoods elsewhere in the county cannot access these resources and have limited choice when it comes to diet and nutrition. Approximately 99 organizations throughout Forestland provide some type of financial assistance to participants. Two Financial Empowerment Centers that offer free individual, professional financial counselling are located in Forestland. There are 85 non-profit agencies that provide housing services located in Forestland. Many of these agencies provide housing services to special populations, such as: victims of domestic violence, people living with HIV/AIDS, people with mental illness, and homeless veterans. There are 68 local government agencies such as food stamp programs, Medicaid offices, and job centers, all clustered in and around northern/central Forestland. There are 32 community outreach agencies that provide services ranging from homeless outreach to mobile health vans. There are 15 transportation service organization in Forestland, most providing transportation needs to seniors and the disabled. There are 574 Department of Youth and Community Development-funded programs located in Forestland, of which 402 are after-school programs. These programs are perceived as essential to keeping at-risk youths away from gun violence and substance abuse. There are 903 schools in Forestland, as well as five public colleges. Additionally, there are 192 community-based organizations in Forestland providing educational services. Some of these organizations focus on special populations such as children with emotional disturbances, at-risk youth, immigrants, and refugees. There are approximately 15 organizations that offer criminal justice offender services located in Forestland. These services include: outpatient substance use treatment, job skills training, case management, referrals to mental health and medical treatment, youth-specific programming and employment.

- Outline how the composition of the community resources are needs to be modified to meet the needs of the community.

PPS Response (Limited to 400 Words)
Many of the food pantries that are available in low-income neighborhoods contain only highly processed and preserved foods, which undermine efforts to maintain healthy lifestyles and disease management by regulating salt and fat intake.

The process for booking, confirming and being picked up by transportation services is bureaucratic and complicated. These administrative hurdles drastically lower the accessibility of transportation services for those who need them most.
A primary concern with youth development programs is that they tend to close in the summer months, when school-age youths need them most.
Like with its healthcare resources, Forestland's community resources have an issue with resource distribution. Many community resources are located in wealthier areas, rather than the more deprived areas where the need lies. This makes many such resources inaccessible to lower-income individuals.
Access to affordable healthy food and nutrition is another key social issue in Forestland, especially in light of the prevalence and impact of Diabetes (which is one of the key drivers of avoidable hospital admissions). Nutritional and lifestyle advice are similarly lacking.

Scoring Process	This response ***is worth 10%*** of the total points available for *Section 3 – Community Needs Assessment*. The response will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.

Community Demographics
Demographic data is important to understanding the full array of factors contributing to disease and health. Please address the following in the response:

- Provide detailed demographic information, including:
  - Age statistics of the population;
  - Race/ethnicity/language statistics of the population, including identified literacy and health literacy limitations;
  - Income levels;
  - Poverty levels;
  - Disability levels;
  - Education levels; and
  - Employment levels.

  Please note, demographic information should also include those who are institutionalized, as well as those involved in the criminal justice system.
  As necessary, please include relevant attachments supporting the findings.

PPS Response (Limited to 1000 Words)
Forestland's population of 2.5 million is approximately one-third of the total GFL population, and approximately 13% of the statewide population. Approximately two-thirds of Forestland's population are working age adults, between 18 and 64; approximately one quarter are children, and just over ten percent are older adults, aged 65 or older. Slightly more than half of the Forestland population is female, roughly analogous to the populations of GFL and NYS.

Forestland's population is extremely racially and ethnically diverse. Approximately one in three (34.2%) people in Forestland identify as Black or African American, a much larger proportion than in GFL as a whole (25.1%). The Black population includes US born and immigrant populations, including significant numbers from the Caribbean islands. Approximately one-fifth (19.8%) of Forestland identifies as Hispanic/Latino. Approximately one in ten (10.6%) people in Forestland identify as Asian.
Approximately 17% of Forestland's population are not US citizens, but this figure likely underestimates the immigrant population in Forestland, because the number of undocumented individuals is reported to be substantial. Approximately 22,600 thousand people in Forestland are reported to have migrated to the United States less than one year ago, and approximately one in four people (566,247) report speaking English less than "very well." Nearly half (46%) of Forestland residents report speaking a language other than English at home. Within the county, high proportions of non-citizens are found in Sap Valley and Cedar Bay. These areas, along with Plum Ridge and Juniper Hill, also have high rates of residents who speak English less than "very well".
Those who are not US citizens and who speak English less than "very well" may experience additional regulatory or cultural barriers to health care access. Among the undocumented population, the concerns of other immigrant populations are further magnified. Access to most services is limited, and the fear of deportation results in lower utilization of services that are available, including health services. Providers report that people who are undocumented want to avoid providing information about themselves, and avoid "the system" to the greatest extent possible.
The median household income in Forestland is approximately $45,000 per year, lower than GFL ($52,000) and NYS ($58,000). Slightly more than one in five (22%) households in Forestland lives below the federal poverty level, and furthermore, these figures are not adjusted for the comparative cost of living in Greater Forestland versus other parts of NYS where the cost of living may be lower. The highest rates of poverty are in northern and northeastern parts of the County, in the neighborhoods of Maple Hill-Sap Valley, East Forestland, and parts of Hazelcrest, where approximately one in three households have incomes below the federal poverty level.
Trends in primary data collection activities suggest that, for some communities, including a number of immigrant groups, economic constraints are countered with very long work hours and multiple jobs, which make it extremely challenging to maintain good health habits. In some low income communities, working 18 to 20 hours each day is the norm, done across two to three jobs. With such a lifestyle, accessing health services – especially when they are not open past the evening – is extremely difficult.
Approximately eight out of ten (78%) Forestland residents aged 25 or higher has a high school degree or equivalent, on-par with GFL (79%), but lower than NYS (85%). The overall unemployment rate in Forestland is 10.3%, approximately the same as the rate for GFL (10.2%) but higher than the rate for NYS (8.7%). Unemployment in the county varies greatly from 6.2% to 17.7% with the highest rates in the northern and central portions of the county, and Juniper Hill.
There are approximately 1.3 million Medicaid beneficiaries living in Forestland. The percentage of the Forestland population who are Medicaid Beneficiaries varies across zip codes from 11.8% to 84.9%. The highest proportion of the population who are Medicaid Beneficiaries are in two large clusters, one in the northeast part of the county from Maple Hill through Sap Valley, Hazelcrest, Sweetgum, and East Forestland; and the other in southwest and south central Forestland, from Cedar Bay to Tulip Park, Birchview, East Birchview, and Cherryburst. Approximately half (52%) of the Forestland older adult population of 290,700 thousand is dually eligible for Medicaid and Medicare.
In Forestland, approximately 344,000 people are uninsured, accounting for approximately 16% of all the uninsured individuals in New York State. Adults over the age of 18 account for the largest

proportion of the uninsured in Forestland, with a rate of 16.9%, versus approximately 2% among those aged 65 and older, and 4.5% among children aged 0-17. Within the county, the highest number of uninsured are clustered in the zip codes of Cedar Bay and East Birchview, with high numbers in Maple Hill-Sap Valley, East Forestland, and East Birchview.
A significant portion of the uninsured in Forestland may be undocumented, creating significant challenges in terms of engaging these individuals in health services. Income restrictions for Medicaid are considered unrealistically low by our respondents, and self-purchased coverage was repeatedly described as too expensive, given the difficulties of paying for basic necessities including food and housing. Lack of health insurance was reported to result in reduced use of preventive and community based care and increased emergency department use.
While crime has been declining overall in Forestland for the past 15 years, the issue persists in areas where crime, including gun violence, is cited as a serious barrier to accessing (and providing) services due to personal safety concerns.

Scoring Process	This response ***is worth 15%*** of the total points available for *Section 3 – Community Needs Assessment*. The response will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.

Community Population Health & Identified Health Challenges
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:

- Identify leading causes of death and premature death by demographic groups;

PPS Response (Limited to 150 Words)
Heart disease is the leading cause of death among White, Black, and Hispanic populations in Forestland. The top ten causes in order are: diseases of the heart, cancer, influenza and pneumonia, diabetes, chronic lower respiratory disease, cerebrovascular disease (stroke), essential hypertension and renal diseases, accidents except drug poisoning, HIV, mental and behavioral disorders due to accidental poisoning and other psychoactive substance use, and all other causes. The top five causes of premature death (death before the age of 75) in Forestland are cancer, heart disease, unintentional injury, diabetes and AIDS.

- Leading causes of hospitalization and preventable hospitalizations by demographic groupings;

PPS Response (Limited to 150 Words)
Overall, the rate of Potentially Preventable (PQI) Admissions in Forestland has been declining since 2009, but is above the statewide rate. The majority of PQI admissions in Forestland is for chronic conditions, which have also declined since 2009 but remain above the statewide rate.

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

PPS Response (Limited to 150 Words)

Forestland has fewer potentially avoidable emergency room visits (PPV) per 100 beneficiaries than GFL or NYS. Despite this, the proportion of emergency visits that are considered potentially preventable is high at 74.5%. A number of factors contribute to non-emergent use of hospital emergency departments: wait times for appointments, wait times on the day of the visit, and the potential need for multiple visits in regular care. Even long waits in the ER are perceived to represent a more efficient use of time than waiting weeks for a doctor's appointment.

- Disease prevalence such as diabetes, asthma, cardiovascular disease, depression and other behavioral health conditions, HIV and STDs, etc.;

PPS Response (Limited to 400 Words)

The number of stresses on lower income Forestland residents are overwhelming to some and result in high levels of depression. Low-income immigrant populations have additional stressors, as well as poorer access to care, due to insurance and language issues. Access to mental health services is reported to be limited, although community organizations and residents are not always aware of available services or how to access them. In addition, behavioral health issues generally carry greater stigma than other health concerns, which further limits use of services. Key informants and focus group participants both reported that many affected families try to address problems internally.
Many patients with behavioral health conditions also have chronic physical health conditions. According to data from the NYS Office of Mental Health (OMH), approximately 54.8% of Forestland clients served had at least one chronic medical condition.
Diabetes is considered by many residents and key informants to be the most significant health issue in Forestland. The number of beneficiaries in Forestland who had a diabetes-related service utilization totaled 139,755 in 2012, representing 11.3% of the beneficiary population. Across New York State, only 51% of Medicaid Managed Care beneficiaries with diabetes received all recommended tests in the last year, and 33% of Medicaid Managed Care beneficiaries in NYS with diabetes have poorly controlled HbA1c, leading to significant PQI Admissions.
The rate of age-adjusted heart attacks is higher in Forestland (15.9 per 10,000) than in the city (13.5 per 10,000) or the state (15.1 per 10,000);s 25.3% of Forestland clients served due to a chronic condition had a cardiovascular condition such as hypertension In 2012, the number of potentially preventable hospitalizations among Medicaid beneficiaries for circulatory conditions (PQI S02 Circulatory Composite) in Forestland was 3,694, accounting for more than one in five (23.3%) of all such admissions in the State.
6% of Medicaid beneficiaries in Forestland currently suffer from respiratory conditions such as asthma or COPD, accounting for 25.3% of the potentially preventable hospitalizations caused by chronic

conditions in Forestland. There is a recognized need in the community for services specifically tailored to respiratory conditions, but few real resources currently exist.
Across chronic conditions, there is a great deal of overlap, as 48% of patients with one chronic condition had an additional comorbidity (typically diabetes and hypertension). This overlap in required care heightens the need in Forestland for a more integrated delivery system of care for high-risk populations.

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

PPS Response (Limited to 150 Words)

With regard to maternal health, over the period 2010-2012 Forestland averaged 41,969 live births per year, 65.9% of which were Medicaid or self-pay. The overall Low Birth Weight (LBW) rate for Forestland over the same time period was 8.2%, compared to 8.5% for GFL and 8.1% for the state. Across zip codes, the LBW rates ranged from 5.2% to 13.4%, with the highest rates found in a large cluster of zip codes extending through the north central, central, and eastern parts of the county in the neighborhoods of Hazelcrest, Chestnut Heights, Birchview, Sweetgum, East Forestland, and Willow Flatlands. These neighborhoods also experience the highest rates of infant mortality. Access to prenatal care is considered poor in the same zip code cluster, with a widespread lack of education of fetal health leading to the higher recorded rate of infant mortality.

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

PPS Response (Limited to 150 Words)

The greatest health risk factor in Forestland is obesity, as the prevalence of obesity in Forestland is higher than in GFL or NYS, with just over one-quarter (27%) of all adults in Forestland obese. Community members attributed obesity to dietary behavior, which in turn was attributed to food availability, as well as lack of knowledge, lack of time, lack of money, and ingrained habits. Although many communities did have farmers markets, they are notably absent in the most high-risk areas and are often held just once a week and operating during regular business hours so were not accessible to working people. Dietary issues went beyond access: participants described the difficulty of changing behavior. Working parents had little or energy time to shop and cook, so offered their children fast food as the inexpensive, easy, and likely to please, alternative. Such patterns were considered ingrained.
Another health risk factor affecting Forestland is smoking and tobacco use. The percentage of cigarette smoking among adults in Forestland is roughly on par with GFL and NYS rates. Smoking was considered problematic among particular populations, including Chinese and Arab immigrants. Among Arab populations, smoking is considered an indicator of maturity, and offering cigarettes is a common courtesy. In addition, the increasing number of hookah bars in Arab neighborhoods was also an issue of concern.

Scoring Process	This response ***is worth 15%*** of the total points available for *Section 3 – Community Needs Assessment*. The response will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.

Healthcare Provider and Community Resources Identified Gaps

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

- Identify the health and behavioral health service gaps and/or excess capacity that exists in the community, ***specifically outlining excess hospital and nursing home beds*.**

PPS Response (Limited to 400 Words)
The primary health service gaps in Forestland are most prominent for chronic conditions, including cardiovascular conditions such as hypertension, diabetes, and behavioral health. The Medicaid beneficiaries that account for the largest proportion of preventable admissions related to these conditions are concentrated in the areas of Northern/Central Forestland and Juniper Hill-Ash Park. These areas also account for the highest proportion of potentially preventable emergency room visits (PPV) and overall potentially preventable hospital admissions (PQI). A key component of DSRIP is to reduce avoidable hospital visits and admissions by bolstering primary care providers and community based organizations (CBOs) to enhance coordination of care, prevention and disease management, particularly for those with chronic conditions. Currently, the distribution of primary care providers is uneven in Forestland, with sparse numbers in certain neighborhoods. But perhaps as important, their capacity, quality, linkages to broader health care delivery systems and operating hours do not seem to be adequate in some high need areas, for example in northern and central Forestland.. On the other hand, current levels of hospital beds are already high in Forestland. A reduction in hospital activity will result in significant over-capacity, with as many as 1450 beds (25%) becoming redundant by the end of DSRIP Demonstration Year 5. Of the 10,246 nursing home beds, as many as 2560 may become excessive by the end of DSRIP. This will require the reconfiguration of our Poplar Hospital Medical Center, turning it into an entirely outpatient facility, as well as the re-organization and redistribution of remaining inpatient services across the remaining facilities. A defined plan for this multi-partner reorganization (including the enhanced governance structure that will accompany that plan) will be created during DY1. Another large gap in healthcare in Forestland is the low number of resources set aside for increasingly valued services, such as care coordination. Resources are limited for these positions, meaning that salaries for the positions were relatively low. Low salaries make hiring difficult and may necessitate selection of candidates that are under-qualified, particularly considering the expectations of the job. These expectations may include familiarity with multiple services (e.g., medical services, housing service, insurance information, etc.); ability to work with relatively difficult populations, including clients with behavioral health issues; and ability to use multiple electronic record systems, because of the multiple partner organizations. Lack of trust or engagement (or possibly time) in care coordination

on the part of medical providers also was considered to limit the potential effectiveness of care coordination models.

- Include data supporting the causes for the identified gaps, such as the availability, accessibility, affordability, acceptability and quality of health services and what issues may influence utilization of services, such as hours of operation, and transportation that are contributing to the identified needs of the community.

PPS Response (Limited to 300 Words)

The areas where the largest healthcare gaps exist in terms of care for chronic conditions also consistently have high rates of household poverty, high rates of unemployment and uninsured, and low levels of education. In addition, there are a large number of immigrants—including many undocumented—in these Forestland neighborhoods with access barriers (e.g., linguistic, eligibility for insurance) that go beyond those of other populations.
Therefore, though the main health gaps are on caring for diabetes, obesity, cardiovascular disease and depression, the data strongly indicates that these gaps are intimately related to these broader socio-economic issues. Addressing these health gaps thus means coordinating community based resources and improving access to affordable housing, debt reduction, and food programs.
In addition, there are particular populations, including the chronically street homeless who tend to have severe alcohol dependence and/or co-occurring behavioral health disorders and who are particularly high users of emergency departments – some with multiple visits in a single day. Targeted services offered in emergency departments that proactively connect frequent users to shelters, other community resources and high-functioning PCMHs have been shown to significantly reduce visits and costs.

- 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 develop new or expand current resources or alternatively to repurpose existing resources (e.g. bed reduction) to meet the needs of the community.

PPS Response (Limited to 300 Words)

The strategy to address the identified gaps in care for Medicaid suffering from chronic conditions such as behavioral health issues, cardiovascular disease, and diabetes will have several areas of focus. First, the delivery of health services to these high-risk populations needs to become more integrated, with particular attention placed on dedicated care coordinators managing care transitions from primary care to acute care to community care. Integrating health providers from across the spectrum of care through the Forestland Health PPS will both reduce PQI Admissions by providing greater accessibility to community health services, and also reduce PPR Readmissions by ensuring that patients leaving the hospital have the resources they need to manage their chronic conditions effectively.

An additional point of the strategy to address these gaps is to take solid steps towards integrating and engaging the uninsured in available health resources outside of the Emergency Department. Too often, the uninsured see the ED as their only way to access the healthcare system, when there is already designated resources assigned to meeting their needs.
Furthermore, greater emphasis will be placed on making primary care an attractive and accessible alternative to the Emergency Department for non-urgent care needs. This shift will require a dramatic change in opening times and operating procedures of these PCPs, novel care pathways and the education of high-ED-user populations such as the uninsured and non-English-speaking individuals. Particular focus will be placed upon making it easier for Medicaid beneficiaries to manage behavioral health, cardiovascular, and diabetes related issues, in order to prevent complications and avoidable hospital admissions. This will involve strengthening care linkages, introducing multi-service 'one-stop-shopping' to handle routine health needs of patients with co-morbidities, and increasing operating hours to allow for individuals with intensive work schedules to still meet their basic health needs.

Scoring Process	This response ***is worth 15%*** of the total points available for *Section 3 – Community Needs Assessment*. The response will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.

Stakeholder & Community Engagement

It is critically important the PPS strategy be developed through collaboration and discussions to collect input from the community the PPS seeks to serve. Please address the following in regards to stakeholder and community engagement:

- 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).

PPS Response (Limited to 300 Words)

The stakeholder and community engagement process undertaken in developing the CNA began by advertising the Forestland CNA upcoming process on Forestland Health's website, as well as many other health resource websites throughout the county. The website explained the upcoming CNA process, and the PPS' promise to engage the community in its assessment of Forestland's health needs. The goal of the CNA, the website explained, was to answer the following questions:

- To what extent are community and environmental conditions conductive to health promotion and disease prevention?
- What are the primary health concerns and health needs of residents, overall and according to neighborhood and demographic characteristics?
- What are the health related programming and services available to community residents, what organizations are providing the services, and what are the service gaps?

The next step in stakeholder engagement was a survey completed by 600 Forestland residents. Survey respondents were identified and recruited by local organizations, including community based organizations, senior centers, social service and health providers, and through WAM initiated street

outreach—at street fairs, subway stops, and other places where people congregate—in targeted low-income neighborhoods. Although the sample cannot be considered representative of the county in a statistical sense, and gaps are unavoidable, the combination of street and organizational outreach facilitated engagement of a targeted yet diverse population, including both individuals connected and unconnected to services. Surveys were self-administered or administered by WAM staff or staff or volunteers at community organizations.
20 key informants were interviewed across GFL, including 10 whose work focused largely or solely on Forestland. Key informants were selected with input from the PPS's. A portion had population specific expertise, including particular immigrant groups, older adults, children and adolescents. All key informants were asked about perceptions of health issues in the community, barriers and facilitators to good health, health care and other service needs, and recommendations for services and activities that may benefit the local population. Follow-up questions, asked on ad hoc basis, probed more deeply into the specific areas of expertise of key informants.

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

PPS Response (Limited to 150 Words)

5 focus groups were conducted with Forestland community members, including residents from low income neighborhoods and residents identified as having unique health and service needs, including individuals with behavioral health issues, older adults, survivors of domestic violence, LGBTQ, and immigrants and/or other limited English proficient (LEP) individuals. Focus group participants were recruited by local organizations, community based organizations, senior centers, social service providers, tenant associations, and health providers. Community member interest in the focus groups was high, with group size ranging from 20 to 54.

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

PPS Response (Limited to 150 Words)

From the stakeholder engagement process, it was discovered that though many community services exist, the populations that need them most do not find them accessible. This is due to long distances between low income neighborhoods and some key community resources, service operating hours that do not cooperate with low income employees' busy work schedules, and widespread stigma against using community services, particularly in the case of behavioral health issues.

Scoring Process	This response ***is worth 5%*** of the total points available for *Section 3 – Community Needs Assessment*. The response will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.

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 the organization, and why each organization is important to the PPS strategy.

Organization	Brief Description	Rationale
Forestland Farmers Markets Group	The most popular weekend farmers market in Forestland	Increasing accessibility to healthy options will assist patients with obesity, cardiovascular health issues, and/or diabetes
The Forestland Alliance on Mental Illness (FAMI)	Offers education and support for behavioral health issues	Improving behavioral health services and removing stigma is a large part of the PPS strategy
The Forestland Catholic Progress of Peoples (FCPOP) Foundation	Turns vacant land and buildings into affordable housing complexes for people in need across many religious denominations (with a focus on members of the Catholic Church)	Access to affordable housing is a significant determinant to health, and improving housing access for Medicaid beneficiaries in Forestland is a key part of the strategy
Forestland Financial Empowerment Center	Provides financial assistance to uninsured families in Forestland	Engaging with the Uninsured population to improve their health is important for reducing preventable ED visits
Sap Valley Outreach Center	Provides transportation services for seniors and the disabled, allowing them to attend health services	Makes healthcare more accessible for at-risk populations, a key piece of the strategy
Forestland Seniors Association	Supports seniors who live alone	Lowering preventable readmissions from seniors with chronic conditions is part of the strategy
Birchview Community Support Group	Provides financial assistance, food supplies, and after school programs to families below the poverty line	Learning about the health needs of at-risk populations provides the information necessary to improve healthcare for those populations
Forestland Welcoming Center	Provides educational and language service for new immigrants in Forestland	Making healthcare more accessible for the culturally diverse population of Forestland is important to the strategy

Summary of CNA Findings

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 should be designated with a unique community need identification number. The needs should be those 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 re-enforcing the rational for project selection. ***Finally, please attach the CNA report completed by the PPS during the DSRIP design grant phase of the project.***

Scoring Process	This response ***is worth 20%*** of the total points available for *Section 3 – Community Needs Assessment*. The response will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.

Community Need Identification Number	**CNA Title – link to selected project**	**Brief Description**	**Primary Data Sources**
CNA 1	Need for delivery system integration across the spectrum of care	Healthcare is currently very segregated by acute care, primary care, behavioral health, etc., but chronic condition patients need smooth transitions across all categories. This project will include a Medical Village subproject.	WAM Primary Data Collections, surveys and focus groups 1-5, preliminary findings Potentially Avoidable Emergency Room Visits Potentially Avoidable Readmissions PQI Suite – Composite of all measures – AHRQ PDI Suite – Composite of all measures - AHRQ *NYS Office of Health (NYSOH), Office of Performance Measurement and Evaluation. 2012 or 2013. July, 2014*
CNA 2	Need for accessible primary care as an alternative to the emergency department	The emergency department is currently the preferred source of care for the uninsured and Medicaid beneficiaries that do not have access to primary care. This is highly expensive and inefficient, when the care required could be provided by a primary care provider	WAM Primary Data Collections, surveys and focus groups 1-5, preliminary findings H-CAHPS – Care Transition Metrics CAHPS Measures – Care Coordination with provider up-to-date about care received from other providers *NYS Office of Health (NYSOH), Office of Performance Measurement and Evaluation. 2012 or 2013. July, 2014*
CNA 3	Need for a Medical Home using existing hospital infrastructure	A significant amount of hospital capacity is currently outdated and underused – this infrastructure can be converted into a stand-alone urgent care center, with a strong emphasis on care coordination	WAM Primary Data Collections, surveys and focus groups 1-5, preliminary findings Potentially Avoidable Emergency Room Visits Potentially Avoidable Readmissions PQI Suite – Composite of all measures – AHRQ PDI Suite – Composite of all measures - AHRQ *NYS Office of Health (NYSOH), Office of Performance Measurement and Evaluation. 2012 or 2013. July, 2014*

CNA 4	Need for greater care transition support to prevent 30-day readmissions for at-risk populations	Currently, many patients with chronic conditions are readmitted to acute care within 30 days because there was no support to assist their transition to community, home, or hospice care. These are preventable hospitalizations that can be dramatically reduced. Although we identified an issue with SNF readmissions as well, the potential improvement of this project is significantly larger.	WAM Primary Data Collections, surveys and focus groups 1-5, preliminary findings H-CAHPS – Care Transition Metrics CAHPS Measures – Care Coordination with provider up-to-date about care received from other providers *NYS Office of Health (NYSOH), Office of Performance Measurement and Evaluation. 2012 or 2013. July, 2014*
CNA 5	Need for greater integration of primary care and behavioral health services	Currently, behavioral health is seen as inaccessible, and behavioral patients perceive themselves as marginalized by the healthcare system.	WAM Primary Data Collections, surveys and focus groups 1-5, preliminary findings PPV (for persons with BH diagnosis) Antidepressant medication Management – NCQA Diabetes Monitoring for People with Diabetes and Schizophrenia – NCQA Cardiovascular Monitoring for People with CVD and Schizophrenia NCQA Follow-up care for children prescribed ADHD medications – NCQA Follow-up after hospitalization for Mental Illness – NCQA Screening for Clinical Depression and follow-up – NCQA Adherence to Antipsychotic Medications for People with Schizophrenia – NCQA *NYS Office of Health (NYSOH), Office of Performance Measurement and Evaluation. 2012 or 2013. July, 2014*
CNA 6	Need for behavioral health community crisis stabilization services	Currently, many behavioral health patients end up in acute care facilities for extended period of times because they lack support and assistance in the community. Increased community care can prevent these extended hospitalizations	WAM Primary Data Collections, surveys and focus groups 1-5, preliminary findings PPV (for persons with BH diagnosis) Antidepressant medication Management – NCQA Diabetes Monitoring for People with Diabetes and Schizophrenia – NCQA Cardiovascular Monitoring for People with CVD and Schizophrenia NCQA Follow-up care for children prescribed ADHD medications – NCQA Follow-up after hospitalization for Mental Illness – NCQA Screening for Clinical Depression and follow-up – NCQA Adherence to Antipsychotic Medications for People with Schizophrenia – NCQA

			NYS Office of Health (NYSOH), Office of Performance Measurement and Evaluation. 2012 or 2013. July, 2014
CNA 7	Need for evidence-based strategies for cardiovascular disease in at-risk populations	Currently, diseases of the heart are the most common reason for death in Forestland. Leading practices for managing cardiovascular health exist and need to be put into practice by the health system	WAM Primary Data Collections, surveys and focus groups 1-5, preliminary findings PQI #7 (HTN) – AHRQ PQI #13 (Angina without procedure) – AHRQ Cholesterol Management for Patients with CV Conditions – NCQA Controlling High Blood Pressure (provider responsible for medical record reporting) – NCQA Aspirin Discussion and Use – CAHPS Medical Assistance with Smoking Cessation – NCQA Flu Shots for Adults Ages 50 – 64 – NQCA Health Literacy Items - CAHPS *NYS Office of Health (NYSOH), Office of Performance Measurement and Evaluation. 2012 or 2013. July, 2014*
CNA 8	Need for evidence-based strategies for diabetes in at-risk populations	Currently, 33% of Forestland beneficiaries with diabetes describe it as poorly controlled. Diabetes can be managed and this will reduce preventable hospitalizations. The potential improvement in DSRIP metrics possible, combined with the size of the affected subpopulations, made us prioritize Diabetes and CVH over COPD/Astma, HIV/AIDS, renal failure and palliative care.	WAM Primary Data Collections, surveys and focus groups 1-5, preliminary findings PQI #1 (DM Short term complications) – AHRQ Comprehensive Diabetes screening (HbA1c, lipid profile, dilated eye exam, nephropathy) – NCQA Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) Comprehensive Diabetes Care – LDL-c control (<100mg/dL) Medical Assistance with Smoking Cessation Flu Shots for Adults Ages 50 – 64 – NQCA Health Literacy Items - CAHPS *NYS Office of Health (NYSOH), Office of Performance Measurement and Evaluation. 2012 or 2013. July, 2014*
CNA 9	Need for strengthened mental health and substance abuse infrastructure across systems	Currently, mental health patients and substance abusers are not seeking a solution from the health system because it does not have the infrastructure to support them. The Forestland health system needs to engage them before the ED	WAM Primary Data Collections, surveys and focus groups 1-5, preliminary findings Age-adjusted percentage of adults with poor mental health for 14 or more days in the last month – BRFSS Age-adjusted percentage of adult binge drinking during the last month – BRFSS Age-adjusted suicide death rate per 100,000 – NYS NYSDOH Vital Statistics *NYS Office of Health (NYSOH), Office of Performance Measurement and Evaluation. 2012 or 2013. July, 2014*
CNA 10	Need for increased access to high quality	Currently, 72% of preventable hospitalizations in Forestland are due to	WAM Primary Data Collections, surveys and focus groups 1-5, preliminary findings Percentage of adults who are obese – BRFSS

	preventative care for chronic conditions in both clinical and community settings	chronic conditions. Making preventative care accessible today will dramatically reduce the need for these hospitalizations later	Percentage of children and adolescents who are obese – BRFSS Percentage of cigarette smoking among adults – BRFSS Percentage of adults who receive a colorectal cancer screening based on the most recent guidelines (aged 50-75 years) BRFSS Asthma emergency department rate per 10,000 – SPARCS Asthma emergency department rate per 10,000 (aged 0-4 years) – SPARCS Age-adjusted heart attack hospitalization rate per 10,000 – SPARCS Rate of hospitalizations for short-term complications of diabetes per 10,000 (aged 6-17 years) – SPARCS Rate of hospitalizations for short-term complications of diabetes per 10,000 - SPARCS *NYS Office of Health (NYSOH), Office of Performance Measurement and Evaluation. 2012 or 2013. July, 2014*
CNA 11	Need for patient activation and engagement to integrate the uninsured in community care	Currently, the only contact the uninsured have with the health system is through the ED. Engaging this population in community care can reduce their reliance on costly ED over-usage	WAM Primary Data Collections, surveys and focus groups 1-5, preliminary findings Rate of uninsured ED usage per 10,000 vists - NCQA *NYS Office of Health (NYSOH), Office of Performance Measurement and Evaluation. 2012 or 2013. July, 2014*

*Community need identification number will be automatically generated by the online application.

Section 4 – DSRIP Projects

2.a.i Create an Integrated Delivery System focused on Evidence-Based Medicine and Population Health Management

Project Objective: Create an Integrated Delivery System focused on Evidence-Based Medicine and Population Health Management.

Project Description: This project will require an organizational structure with committed leadership, clear governance and communication channels, a clinically integrated provider network, and financial levers to incentivize and sustain interventions to holistically address the health of the attributed population and reduce avoidable hospital activity. For this project, avoidable hospital activity is defined as potentially-preventable admissions and readmissions (PPAs and PPRs) that can be addressed with the right community-based services and interventions. This project will incorporate medical, behavioral health, post-acute, long term care, social service organizations and payers to transform the current service delivery system – from one that is institutionally-based to one that is community-based. This project will create an integrated, collaborative, and accountable service delivery structure that incorporates the full continuum of services. If successful, this project will eliminate fragmentation and evolve provider compensation and performance management systems to reward providers demonstrating improved patient outcomes.

Each organized integrated delivery system (IDS) will be accountable for delivering accessible evidence-based, high quality care in the right setting at the right time, at the appropriate cost. By conducting this project, the PPS will commit to devising and implementing a comprehensive population health management strategy – utilizing the existing systems of participating Health Home (HH) or Accountable Care Organization (ACO) partners, as well as preparing for active engagement in New York State's payment reform efforts.

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the document, **Domain 1 DSRIP Project Requirements Milestones and Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements.

1. All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary, to support its strategy.
2. Utilize partnering HH and ACO population health management systems and capabilities to implement the strategy towards evolving into an IDS.
3. Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.
4. Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners,

includingDirect exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.

5. Ensure that EHR systems used by participating safety net providers must meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year (DY) 3.
6. Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.
7. Achieve 2014 Level 3 PCMH primary care certification for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of Demonstration Year (DY) 3.
8. Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.
9. Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.
10. Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.
11. Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.

Project Response & Evaluation (Total Possible Points – 100):

1. **<u>Project Justification, Assets, Challenges, and Needed Resources</u> (1500 word limit, Total Possible Points – 20)**
   a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design and sites included. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

PPS Response (Limited to 500 Words)
As our CNA results show, the majority of potentially preventable admissions in Forestland are for beneficiaries with chronic conditions. The proportion of ER visits that are potentially preventable is currently high, at 74.5%, with a large proportion of chronic and multi-morbid conditions could have benefited from a more evidence based treatment approach. Physical and behavioral health problem often co-occur: 55% of behavioral health clients have at least one chronic medical condition. Our current delivery system is not optimally equipped to deal with the needs of these populations. Fragmentation between and within primary, secondary, community and behavioral health services is a fundamental problem throughout Forestland. The need for patients with multiple chronic conditions to make multiple visits to fragmented providers for different aspects of their care is a key cause of avoidable ER visits. Patients would rather wait at the ER than go to multiple locations for their different needs. More fundamentally, the lack of an integrated, pro-active approach to the care for chronic patients results in high rates of preventable admissions, often preceded by an acute exacerbation which could have been equally preventable. The breaking down some of the silos that

have prevented cross-organizational care coordination and care pathway development in the past is a high priority.

In addition to fragmentation, another core underlying driver is the uneven distribution of primary care providers, with sparse numbers in certain neighborhoods and insufficient operating hours in some high-need areas – e.g. Northern and C.Forestland. Perhaps as important as the lack of access is the variability in the capacity and organizational maturity of primary care providers and their connection with the wider delivery system. There is a lack of easily accessible, community-based, integrated PCMHs (with preventive care, more specialty care and home care capabilities integrated where needed). Creating physical Advanced Primary Care (APC) locations at strategic locations in our geography could provide the 'one-stop shop' that many patients seek (which they subsequently turn to the ER to find). Access to mental health services is particularly limited, and would benefit greatly from integration in these primary care settings. In our vision, reinforced existing community-based care resources to this more viable and preventive-care focused primary care infrastructure will be essential to move from our current, discontinuous 'just-too-late' mode of functioning towards a truly population health approach.
A better-integrated delivery system with coordinated primary, behavioral and community healthcare will benefit the entire attributed population for Forestland PPS – 422,500 beneficiaries, excluding some estimated 100,000 uninsured, and including the attributed Low/Non-Utilizers. Those patients with multiple care needs across different sub-sectors will see the biggest impact, but through the strong focus on community-based prevention that pervades our whole approach the beneficial impact on the health and wellbeing of the communities we serve will be far greater.

b. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

PPS Response (Limited to 300 Words)

Of the 3 hospitals within Forestland PPS, two (Forestland Hospital Center and Rosewood Medical Center) have associated Health Homes, targeting patients with multiple co-morbidities as well as behavioral health and/or social needs. We will leverage the population health management tools in use at these Health Homes, as well as their staff capabilities, to support the expansion in the role of Advanced Primary Care throughout our network. (Our bed reduction approach is explained in proceeding sections)
The Health Home at Forestland Hospital Center has been particularly successful in disease management and admission avoidance. They have recently invested in HealthInsight, a new population health management tool. We are in discussions with a vendor about expanding the scale and scope of this IT platform, so that we can roll it out to include all the providers within the PPS by the middle of Demonstration Year 1.
The 70 accredited PCMH providers in our network vary in their infrastructure and the extent to which they are currently able to effectively coordinate multiple services. We will expand the role and scope of these PCMHs so that they become the focal points for a new model of coordinated, preventive care, with certain PCMHs developing further to Premium APCs (see below).

c. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project, and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

PPS Response (Limited to 500 Words)
The key challenge that we face in the implementation of this project is the same fragmentation of providers that the project itself seeks to tackle. One of the metrics that we will use to measure the performance of the IDS Leadership Team will be the number of provider organizations 'actively involved' in the integrated delivery system. The indicators that will define 'active' involvement will include: the use of patient registries; involvement in coordinated care management (e.g. multidisciplinary team care planning); and the use of an EHR system and other electronic communication with other care providers. Better chronic disease management and admission avoidance will result in a loss of income for some providers in our network, creating a dis-incentive for their active involvement. For some clinicians, time spent involved in case management and multi-disciplinary team meetings may not be rewarded under existing payment systems. However, it is crucial that these providers are actively involved in post-acute care planning and multi-disciplinary case management. Our Funds Flow model is intended to counteract these possible negative incentives, and the IDSLW will be closely involved in the wider work by Forestland PPS on payment reform (see Section 9).

d. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve an overlapping service area. If there are no other PPS within the same service area, then no response is required.

PPS Response (Limited to 300 Words)
Since no adjacent PPSs in the Forestland service area are undertaking project 2.a.i, no coordination activities were planned for this project.

2. <u>System Transformation Vision and Governance</u> (1750 word limit, Total Possible Points – 20)

a. Please describe the comprehensive strategy and action plan for reducing the number of unnecessary acute care or long-term care beds in parallel with developing community-based healthcare services, such as ambulatory, primary care, behavioral health and long term care (e.g. reduction to hospital beds, recruitment of specialty providers, recruitment of additional primary care physicians, hiring of case managers, etc.). The response must include specific IDS strategy

milestones indicating the commitment to achieving an integrated, collaborative, and accountable service delivery structure.

PPS Response (Limited to 1000 Words)

The goal of this project is to create the infrastructure (both physical and virtual) necessary to improve the coordination of care across the network of providers. This is designed so that patients experience seamless care from multiple providers and, where possible, a 'one-stop' experience. The quality of care will be improved through the rapid sharing of comprehensive patient data and cross-organizational, evidence-based care pathways. Furthermore, the combination of behavioral, community and primary care with population health management tools and outcome-based payment reforms will support a shift towards preventive care.

The core pillars of our approach to this project are:

i. Co-location of primary care and behavioral health providers into Standard and Premium APCs (where needed also integrated with more specialist and home care services);
ii. Evolving to full population health management, building on the skills and IT & data infrastructure currently in use by our Health Homes; and
iii. A governance structure that drives better collaboration and coordination, including defined, trans-organizational and multi-disciplinary evidence-based clinical pathways governing the roles of providers and professionals on that pathway

The further evolution of primary care, following the APC Stages of Transformation described in New York's State Heath Innovation Plan, will be central to our approach. This model expands the PCMH model to fully include integrated primary, behavioral, acute and post-acute care, expanding the reach of primary care both further into preventive, community based care as well as incorporating more specialist and home health capabilities to manage chronically ill populations. In our vision, Premium APCs will be the perfect complimentary for our Health Homes, creating a full spectrum of outpatient, prevention oriented, pro-active and coordinated care for the whole population.

This will involve:

- The use of population health management tools and capabilities, drawing on the support of our two Health Homes in unison with our most advanced PCMHs to roll these capabilities out across our region through training and the sharing of infrastructure
- Expanding the scale of centers in order to: accommodate a larger number of primary care clinicians, nurses and support staff; incorporate behavioral health providers; and provide diagnostics and clinical support services on-site where needed
- The inclusion of some specialist outpatient services, including the specialized cardiovascular and diabetes prevention, evaluation and treatment services to be created under projects 3.b.i. and 3.c.i.
- Providing a physical focal point for the care coordination and community outreach workers (delivering the work described under project 4.b.ii)

Of these Premium APCs, we aim to have at least 10 physical locations operating as fully equipped centers, with 24/7 access for urgent care, integrated DTC services and the one-stop-shop capabilities for all care handled by these APCs. This will require significant development of physical infrastructure, starting early 2015 with Hazelcrest and E.Forestland. Given the concentration of high-risk, chronic patient populations around these locations, these facilities have arguably the greatest need for 'one-stop' services to address a significant problem of avoidable ER visits for chronic patients. Our detailed

implementation plan due Apr 1st 2015 will further specify this investment effort. We will be offering incentive payments to primary care physicians to relocate to one of these centers in the network.
The creation of an integrated delivery system will require rapid sharing of data between provider organizations, many of whom are currently small-scale or who will typically be working remotely (see Project 4.b.ii for more on this). We have reviewed the IT infrastructure in place at provider organizations throughout the network, and have mapped which providers have EHRs, the capabilities of these systems, and the extent to which these systems are interoperable. Partners with paper-based systems have been offered several options to move to an electronic platform and we are targeting the beginning of Demonstration Year 2 for the rollout of an inter-operable EHR platform (see also Section 6). Building on the new EHR recently implemented at Forestland Hospital Center and the Population Health System built out from its Health Home, we will develop extensive patient registries, particularly for Diabetes, circulatory diseases and respiratory diseases, given that these are the main drivers of avoidable ER visits. Having interoperable EHR systems throughout the network will also reduce the fragmentation and poor quality of care caused by poor communication and coordination at the point of handover between providers.
The training we will provide on data sharing initiatives and new systems will play an important role in ensuring we meet our targets of: (1) active participation and effective usage of EHR systems and patient registries for all providers in the system by the end of Demonstration Year 2; and (2) meeting Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year 3.

b. Please describe how this project's governance strategy will evolve participants into an integrated healthcare delivery system. The response must include specific governance strategy milestones indicating the commitment to achieving true system integration (e.g., metrics to exhibit changes in aligning provider compensation and performance systems, increasing clinical interoperability, etc.).

PPS Response (Limited to 750 Words)

As well as being a project in itself, this project will provide an overarching governance structure for a number of the other projects within our DSRIP plans. These are the projects that are designed to achieve greater integration of the delivery system and more coordinated population health management (i.e., projects 2.b.ii; 2.b.iv; 3.a.i; 3.b.i; 3.c.i & 4.b.ii).
One of the main aims of the governance structure for this project will therefore be to coordinate the efforts of these projects and ensure that work towards these goals is complementary and there is no unnecessary duplication of effort. We will create a dedicated IDS Leadership Workgroup (IDSLW) to drive the implementation of this project and to oversee the other, complementary projects listed above. This Workgroup reports directly to the Executive Board, and its chair is a member of that Board.

The IDS Leadership Workgroup (IDSW) will be responsible (and held accountable) for:

- Securing the active involvement of all of the providers in the Forestland PPS network in the integrated delivery system. Since the focus of this project will be on bolstering primary and preventive community care, it is the participation of these providers that will be most

important. However, the coordination of clinical handovers between primary and secondary care, for example, and the involvement of specialists in care planning to avoid unnecessary emergency admissions will also be important. The IDSLW will therefore be held accountable for the number of providers actively engaged in the integrated delivery system, with use of a shared or inter-operable EHR platform as a measure of active involvement. Our target is that all of our larger providers and 85% of the total provider group will be using a shared platform by the end of Demonstration Year 3.

- Reducing inpatient bed capacity across the network. One result of more coordinated, preventive care will be a reduction in the number of avoidable (re)admissions. The IDSLW will be responsible for setting targets for this reduction in bed capacity in each Demonstration Year and working with acute providers to achieve these reductions sustainably. This program will need to be aligned with the ongoing work of the Forestland Health Systems Redesign Work Group, established as part of the 2011 state Medicaid redesign program. The restructuring of the financially challenged Poplar Hospital Medical Center into a community hospital with only outpatient facilities will be a central part of this bed reduction. The closure of inpatient facilities at Poplar Hospital Medical Center will constitute a reduction of 110 acute inpatient beds.

  Achieving PCMH Level 3 certification for 85% of PCMHs in the network and 30% Premium APC status at the end of DY 3. Currently, only 10 of the PCMHs in our network (20%) have achieved Level 3 PCMH certification. By the end of Demonstration Year 2 we expect this to be 60% and by the end of Demonstration Year 3, 85%. 30 % will have achieved Premium APC status at that time, and we're aiming at 45% Premium APC status at the end of the DSRIP period.

- Implementing population health management systems. We intend to expand the scope and scale of the HealthInsight population health management platform currently in use at the Forestland Hospital Center Health Home and roll this out to all Forestland PPS PCMHs. As well as the roll out of the IT platform, the IDSLW will be responsible for ensuring the meaningful use of that platform and for ensuring a proactive population health management approach is embedded within the culture of each PCMH.

- Driving payment reform through the creation of outcome-based contracts in collaboration with the MMCs. The IDSLW will meet monthly with the Medicaid Managed Care Organizations to discuss utilization trends, performance issues, and payment reform (for more on our work on payment reform, see Section 9).

Our proposed governance structure is described in Section 2 of this application. The IDSLW will clearly be a key body of this governance structure, and the Executive Committee as well as the PAC and the Clinical, Financial and IT/Data Governance Committees will all be deeply involved throughout this evolutionary process.

As our population health management capabilities grow, and the impact of the projects becomes more substantive, the need will arise to further delegate decision making authority to the NewCo in order to

accommodate the growing need for PPS-level decision making capabilities. Throughout the process, for example, negotiations and collaboration agreements with our MCOs will increasingly occur at PPS level, and more and more investment decisions will have to be made centrally as well.

3. <u>Scale of Implementation</u> (Total Possible Points - 20):

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information:.

a. Please indicate the total number of providers that the PPS intends to include in the IDS by the end of Demonstration Year (DY) 4, or sooner as applicable. This number should be entered in the table as *Total Committed*.

Project Scale	Total Committed (10 Points)	Number of Safety Net Providers*	Percent of Safety Net Providers (10 Points)
Expected # of Hospitals	3	2	25
Expected # of PCPs	250	100	14
Expected # of Nursing Facilities	21	10	35
Expected # of Behavioral Health Providers	10	6	20
Expected # of All Other Providers	10	5	10

**Based on Department of Health Safety Net Provider designation*

b. Please indicate the total expected volume of patients the PPS intends to engage throughout this project by the end of Demonstration Year (DY) 4. This will become the *Expected # of Actively Engaged Patients*. Patient scale is measured by the total number of patients that are expected to be actively engaged by the end of Demonstration Year 4.

Targeted Population to Benefit from Project	422,500
Total Attributed Population	422,500
% of Total Attributed to Benefit from Project	100%

4. <u>Speed of Implementation/Patient Engagement</u> (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application

will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information:

a. Please indicate the Demonstration Year (DY) and Quarter by which all participating providers will achieve project requirements. **Project speed is measured by how fast all the project requirements for all chosen locations are met.**

PPSs will be expected to meet these requirements for all of the providers, sites, or other categories of entities included in the PPS "total committed" scale metric, unless otherwise specified in the Domain 1 DSRIP Project Requirements Milestones and Metrics.

Project Implementation Speed	DY0 (Baseline)		DY1		DY2		DY3		DY 4	
	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4
All Project Requirements Achieved						X				

b. Please indicate the expected timeline for achieving 100% engagement of total expected number of actively engaged patients identified in part a. For example, the PPS may indicate that 25% of patients will be actively engaged by the end of Demonstration Year (DY) 1, 50% by the end of DY2, and 100% by the end of DY 3.

Patient Engagement Speed	DY0 (Baseline)		DY1		DY2		DY3		DY 4	
	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4
Number of *Actively Engaged* Patients	10k	10k	75k	150k	225k	300k	375k	400k	422.5k	422.5k
Expected # of Actively Engaged Patients	422.5k	422.5k	422.5k	422.5k	422.5k	422.5k	422.5k	422.5k	422.5k	422.5k
% of Patients *Actively Engaged*	2.5%	2.5%	18%	36%	53%	71%	89%	95%	100%	100%

For this project, Actively Engaged is defined as patients residing in counties served by the PPS having completed a RHIO Consent Form (including agreeing or denying consent). Please note: It is expected that the baseline number of patients engaged in this project may be 0. If so, please indicate 0 in the Year 0 baseline column.

5. Project Resource Needs and Other Initiatives (750 word limit, Not Scored)

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
X	

If yes: Please describe why capital funding is necessary for the Project to be successful.

PPS Response (Limited to 375 Words)
This project will require capital funding for the development of the APCs throughout the network (in particular where we are developing new physical locations), as well as for the additional required IT investments. Expanding the role and scale of primary care is central to our strategy for improving the coordination and integration of different services. Many of the PCMHs do not currently have the physical capacity, nor some of the technology infrastructure to support their new roles.

b. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
	X

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Name of Entity	Medicaid/Other Initiative	Project Dates	Description of Initiatives

c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

PPS Response (Limited to 375 Words)

6. Domain 1 DSRIP Project Requirements Milestones & Metrics:

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards the implementation of the IDS strategy and action plan, governance, completion of project requirements, scale of project implementation, and patient engagement progress in the project.

a. Detailed Implementation Plan: By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

b. Quarterly Reports: PPS will submit quarterly reports on progress towards achievement of project requirements as defined in **Domain 1 DSRIP Project Requirements Milestones & Metrics.** Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.

2.a.iv Create a Medical Village Using Existing Hospital Infrastructure

Project Objective: To reduce excess bed capacity and repurpose unneeded inpatient hospital infrastructure into "medical villages" by creating integrated outpatient service centers to provide emergency/urgent care as well as access to the range of outpatient medicine needed within the community.

Project Description: This project will convert outdated or unneeded hospital capacity into a stand-alone emergency department/urgent care center. This reconfiguration, referred to as a "medical village," will allow for the new space to be utilized as the center of a neighborhood's coordinated health network, supporting service integration and providing a platform for primary care/behavioral health integration. The proposed medical villages should be part of an "integrated delivery system" and be seen by the community as a "one-stop-shop" for health and health care.

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the document, **Domain 1 DSRIP Project Requirements Milestones and Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements.

1. Convert outdated or unneeded hospital capacity into an outpatient services center, stand-alone emergency department/urgent care center or other healthcare-related purpose.
2. Provide a detailed timeline documenting the specifics of bed reduction and rationale. Specified bed reduction proposed in the project must include active or "staffed" beds.
3. Ensure that all participating PCPs meet NCQA 2014 Level 3 PCMH accreditation and/or meet state-determined criteria for Advanced Primary Care Models by the end of Demonstration Year (DY) 3.
4. Ensure that all safety net providers participating in Medical Villages are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up.
5. Use EHRs and other technical platforms to track all patients engaged in the project.
6. Ensure that EHR systems used in Medical Villages must meet Meaningful Use and PCMH Level 3 standards.
7. Ensure that services that migrate to a different setting or location (clinic, hospitals, etc.) are supported by the comprehensive community needs assessment.

Partners Participating in this Project

Please list the name of the providers for this selected project along with identification numbers.

Provider Name	NPI
Forestland Hospital Center	1467645681

Project Response & Evaluation (Total Possible Points – 100):

1. Project Justification, Assets, Challenges, and Needed Resources (1500 word limit, Total Possible Points – 20)

a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design and sites included. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

PPS Response (Limited to 500 Words)
Our Forestland CNA revealed a number of opportunities for Medical Villages within our Preferred Provider System (PPS) member hospitals. The Medical Village (MV), as defined by DSRIP, will convert unused space at a hospital into needed resources such as urgent care, emergency departments, or other uses in order to become the center of a neighborhood's coordinated care health network. While there are many resources throughout our PPS that offer assistance to patients, they are widely and unevenly distributed. We have chosen the MV to reduce the complexities of finding these resources and to better integrate them so as to assist those patients with chronic conditions and those who need behavioral assistance. Having many resources located together will greatly enhance patient compliance. We have identified Forestland Hospital Center, a larger hospital with an existing health home, to be the site for the first MV. The decision was based on the data from the CNA that revealed that this geographic region, and Forestland hospital itself, have the highest rates of avoidable admits/readmits as well as a significant chronic disease population, second only to Rosewood Medical Center. Forestland Hospital is more central to the GFL area, thereby allowing the highest number of at-risk patients to make use of this MV. The Forestland Hospital location also allows for coordination with our overlapping PPS in the far north. Forestland Hospital is also desirable for its mostly unused building C, offering 70,000 Sq. Ft. of space into which we will build out needed services. Utilizing the existing 40,000 Sq. Ft. of space that is already purposed for PCPs, we will accelerate the acquisition of those PCPs needed and invite the existing, but disjointed and disconnected, alcohol and substance abuse, behavioral health and other programs already in the area to relocate. Including these existing programs will improve community relations and improve patient compliance by using providers known to the at-risk patient populations. Following the successful MV at Forestland Hospital, Rosewood Medical Center (RMC) will be the site of our second MV. Building on the lessons learned at Forestland Hospital, this Medical Village will be established in year 2 of DSRIP and is anticipated to be fully operational and meeting DSRIP goals by DSRIP year four. The RMC service area has the same chronic conditions as are in the Forestland Hospital service area. Even though RMC has the highest rate of potentially preventable readmissions it is at the southernmost portion of GFL which reduces the number patients who can easily access the MV.

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population be specific and could be based on geography, disease type, demographics, social need or other criteria. This patient population that the PPS expects to actively engage over the course of the project will be a subset of the total attributed population.

PPS Response (Limited to 300 Words)
The populations of Forestland Hospital and RMC have overlapping, but slightly different priorities for the MV concept. The CNA gives evidence for high admits and readmits for a number of conditions (see below) and while drug abuse and behavioral health issues have a significant number of available resources they are spread out and not well connected to the health system. Because of the low income and food bank needs around Forestland Hospital, we feel putting a food bank into the MV will enable patients to get appropriate nutrition while seeking medical care in the same venue. Due to the heavy elderly population and the disconnected elderly services in the RMC MV area, the RMC MV will have a unique focus on the frail elderly. We will facilitate these services by pulling from the community services already established, such as local PACE programs. We will also put in interpretive services as this is a linguistically diverse population. The geography has played a significant role in the selection of MV sites. Forestland Hospital is in the central north GFL area while RMC is far south GFL area. With our PPS Partner overlapping in the far north GFL area, the entire GFL area, which has the worst PQI, PPV rates in the county will be well covered. Based on these findings, the target issues of Forestland MV will be: 1. Alcohol and Drug abuse 2. Behavioral Health Issues 3. Asthma 4. Diabetes 5. Cardiovascular Disease 6. Food needs The target issues for the RMC MV will be: 1. Asthma 2. Diabetes 3. Cardiovascular needs 4. Frail Elderly

c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

PPS Response (Limited to 500 Words)
There are a large amount of area resources for behavioral health and substance abuse and we will work with these providers to become partners who have the desire and capacity to open a site within

our MV. In addition, the Forestland Hospital resources dedicated to these issues will be relocated to the medical village central location for ease of access.
There are not enough PCPs to facilitate a well-run MV. Indeed, throughout Forestland we are missing the appropriate number of PCPs and specialists needed, which is generally attributed to the violent crime and gun violence in the area. The Medical Village will be an all-inclusive, secure location that will attract many new providers who have feared establishing practices up until this time. We will have to recruit providers and will target the PCPs and Specialists that are needed while proving for them the infrastructure, technologies, security and comfort needed to alleviate any issues surrounding the violence in some zip codes of GFL.
There are PCPs that we can relocate to our Medical Village for this project. We know that in four zip codes there is a heavy population of PCPs that have been driven there because of the safer neighborhoods. We will reach out to these PCPs to see who is willing to relocate to the new, highly secure MV.

d. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

PPS Response (Limited to 300 Words)

The principle challenge to be addressed is one of safety and security. By placing the first MV in Forestland Hospital, we will create the safest medical zip code in GFL. Secondly, to address the shortage of PCPs and specialists, we will take a three-pronged approach to attract and retain physicians and other direct care providers:

- Improved Infrastructure such as: a learning network to provide CME's and industry updates, secure parking facilities, an athletic club exclusively for providers and employees, PCMH training and implementation services
- Heightened security such as: Cameras, security guards, private garages, security badges to regulate access
- Technology support such as: connectivity to SHIN-NY RHIO, interface solutions, EHR solution and implementation, PHM & PCMH analytical support.

In the event that the first two MVs become saturated with patients, we have planned a third MV, based on need, to be placed in South GFL. In addition we have already taken the step to collaborate with our neighbor PPS in the North to take on many of the Northern patients.

e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve an overlapping service area. If there are no other PPS within the same service area, then no response is required.

PPS Response (Limited to 300 Words)

As noted above, we have taken action to collaborate with our Northern neighbor PPS to locate our MV and theirs so that both of our highest need areas are connected. They will implement their Medical

Village in the far North and ours will be located closer to the central North region. This will allow us to serve the greatest number of patients. In addition, our MV in the southernmost part of GFL will accommodate the rest of the GFL high risk patients while also providing services to those outside the GFL area.

f. Please indicate the total number of staffed hospital beds this projects intends to reduce.

Project Scale	Number of Beds Committed For Reduction
Expected Number of Staffed Beds to be Reduced	231

2. <u>Scale of Implementation</u> (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information.

a. Please indicate the number of Medical Villages this project will establish by the end of Demonstration Year (DY) 4, or sooner as applicable. This number should be entered in the table as *Total Committed*.

Project Scale	Total Committed
Expected Number of Medical Villages Established	3

Please identify the number of committed providers who are a part of the local Safety Net.

Project Scale	Number of Committed That Are Safety Net Providers	Number of Safety Net Providers*	Percent of Safety Net Providers (10 Points)
Primary Care Physicians	20	19	3
Non-PCP Practitioners	15	10	17
Hospitals	1	1	13
Clinics	4	3	7
Health Home/Care Management	2	2	20
Behavioral Health	5	3	10
Substance Abuse	5	3	30
Pharmacy	5	1	5
Hospice	5	2	50
Community Based Organizations	10	0	0
All Other	3	0	0

**Based on Department of Health Safety Net Provider designation*

b. Please indicate the total expected volume of patients the PPS intends to engage throughout this project by the end of Demonstration Year (DY) 4. This will become the *Expected # of Actively Engaged Patients*. Patient scale is measured by the total number of patients that are expected to be actively engaged by the end of Demonstration Year 4

Patient Scale	Commitment
Targeted Population to Benefit from Project	81,120
Total Attributed Population	422,500
% of Total Attributed to Benefit from Project	19%

3. <u>Speed of Implementation/Patient Engagement</u> (Total Possible Points - 40):
DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information.

a. Please indicate the Demonstration Year (DY) and Quarter by which all participating Medical Villages will achieve project requirements. Project speed is measured by how fast all the project requirements for all chosen locations are met**.**

PPSs will be expected to meet these requirements for all of the providers, sites, or other categories of entities included in the PPS "total committed" scale metric, unless otherwise specified in the Domain 1 DSRIP Project Requirements Milestones and Metrics.

Project Implementation Speed	DY0 (Baseline)		DY1		DY2		DY3		DY 4	
	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4
All Project Requirements Achieved								✔		

b. Please indicate the expected timeline for achieving 100% engagement of total expected number of actively engaged patients identified. For example, the PPS may indicate that 25% of patients will be actively engaged by the end of Demonstration Year (DY) 1, 50% by the end of DY2, and 100% by the end of DY 3.

Patient Engagement Speed	DY0 (Baseline)		DY1		DY2		DY3		DY 4	
	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4

Number of *Actively Engaged* Patients	0	0	20260	20260	40530	40530	60800	60800	81120	81120
Expected # of Actively Engaged Patients	81120	81120	81120	81120	81120	81120	81120	81120	81120	81120
% of Patients *Actively Engaged*	0%	0%	25%	25%	50%	50%	75%	75%	100%	100%

For this project, Actively Engaged is defined as the number of participating patients who had two or more distinct non-emergency services from at least two distinct participating providers at a Medical Village in a year. Please note: It is expected that the baseline number of patients engaged in this project may be 0. If so, please indicate 0 in the Year 0 baseline column.

4. Project Resource Needs and Other Initiatives (750 word limit, Not Scored)

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
	X

If yes: Please describe why capital funding is necessary for the Project to be successful.

PPS Response (Limited to 375 Words)

b. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
	X

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Name of Entity	Medicaid/Other Initiative	Project Dates	Description of Initiatives

a. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

PPS Response (Limited to 375 Words)

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards completion of project requirements, scale of project implementation, and patient engagement progress in the project.

a. **Detailed Implementation Plan:** By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

b. **Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.

2.b.ii Development of Co-Located Primary Care Services in the Emergency Department (ED)

Project Objective: To improve access to primary care services with a PCMH model co-located/adjacent to community emergency services.

Project Description: Patients in certain communities are accustomed to and comfortable with seeking their health care services in the hospital setting, frequently leading to overuse of emergency department services for minor conditions while missing preventive health care services. This project will allow faculty to have a co-located primary care PCMH adjacent to the ED. The PCMH practice will have extended hours and open access scheduling. This will allow patients presenting to the ED who, after triage, are found not to need emergency services be redirected to the PCMH, beginning the process of engaging patients in comprehensive primary care.

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the document, **Domain 1 DSRIP Project Requirements Milestones and Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements.

1. Ensure appropriate location of the co-located primary care services in the ED to be located on the same campus of the hospital. All relocated PCMH practices will meet NCQA 2014 Level 3 PCMH standards within 2 years after relocation.
2. Ensure that new participating PCP meet NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of Demonstration Year (DY) 3. At start up, participating PCPs must have open access scheduling extended hours, and have EHR capability that is interoperable with the ED.
3. Develop care management protocols for triage and referral to ensure compliance with EMTALA standards.
4. Ensure EHR utilization including supporting secure notifications/messaging as well as sharing medical records between the participating providers via Meaningful Use standards.
5. Establish protocols and training for care coordinators to assist patients in understanding use of the health system, promote self-management and knowledge on appropriate care.
6. Implement a comprehensive payment and billing strategy. (The PCMH may only bill usual primary care billing codes and not emergency billing codes.)
7. Develop protocols for connectivity to the assigned health plan PCP and real-time notification to the Health Home care manager, as applicable.
8. Utilize culturally competent community based organizations to raise community awareness of alternatives to the emergency room.
9. Implement open access scheduling in all participating primary care practices.
10. Use EHRs and other technical platforms to track all patients engaged in the project.

Partners Participating in this Project

Please list the name of the providers for this selected project along with identification numbers.

Provider Name	NPI
Forestland Hospital Center	1467645681

Project Response & Evaluation (Total Possible Points – 100):

1. **Project Justification, Assets, Challenges, and Needed Resources (1500 word limit, Total Possible Points – 20)**

   a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design and sites included. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

   b.

PPS Response (Limited to 500 Words)
Each of the 3 hospitals in our PPS provides 24/7 ED services. Results from our CNA show that the 74.5% (range 64.6-80.4%) of the emergency visits registered in the communities served by our PPS partners are considered potentially preventable. At 29 potentially avoidable ED visits per 100 Medicaid recipients, our numbers are approximately 10% higher than the state average of 26 avoidable ED visits per 100 recipients. Main factors contributing to the overuse of ED services for non-acute problems are largely linked to (reported) accessibility of regular care, including wait times for appointments, wait times on the day of the visit, and the potential need for multiple visits in regular care. There is also a large perception problem that waiting in the ER is a more convenient and effective use of time that scheduling appointments in regular care. The observed utilization patterns indicate the existence of several large gaps that we will need to address within our PPS. The first is the need for large-scale education of the current and future patient populations that utilizes the ER from the point of view of convenience or due to lack of knowledge of alternative, more cost effective and appropriate options. The second is the uninhibited ease of access to the ER, regardless of the severity of the patient's condition. The third is a need to address the accessibility problem of primary and regular care to Medicaid patients in a manner that will stimulate utilization. At 79.5 FTE primary care physician per 100,000 population, the current levels of primary care access in the Forestland area is considerably lower than NYS (84.5 per 100,000) and GFL levels (90.2 per 100,000). Our strategy will address the interwoven goals of: • Reducing Forestlands' Potentially Preventable ED Visits metric by 25% by the end of DY05 by redirecting patients with non-acute cases to the extended-hours primary care facility and reducing overall cases by initiating community health awareness initiatives, • Optimizing primary care physician capacity and improving accessibility to primary care, especially for Medicaid patients by providing more care coordination services, extending hours and making these resources more accessible to the population most in need of primary care services,

- Engaging and educating the community on health maintenance, preventive care, and proactive scheduling of outpatient resources (thus improving patient education),
- And reducing hospital costs through reduction of ED visits through the aforementioned efforts, allowing for improvements to infrastructure and quality of care with saved funds.

c. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population be specific and could be based on geography, disease type, demographics, social need or other criteria. This patient population that the PPS expects to actively engage over the course of the project will be a subset of the total attributed population.

PPS Response (Limited to 300 Words)

A closer look at the population causing the high observed rates of preventable ED use shows us that the highest utilizers of ED services tend to come from the Northern/Central Forestland, Juniper Hill-Ash Park, and the Cedar Bay neighborhoods. All of these neighborhoods rank consistently high in rates of household poverty, high rates of unemployment and uninsured and low levels of education. In addition, there are a large number of immigrants—including many undocumented—in a number of Forestland neighborhoods with access barriers (e.g., linguistic, eligibility for insurance) that go beyond those of other populations. Approximately 20% of the patients presented at ED present some form of behavioral health or substance abuse problem and among the recurring ED utilizers, this percentage rises to 70%.

Our target patient population for this project is the current and future base of ED utilizers. Given the current rate of 29 avoidable visits per 100 beneficiaries, the number of visits we are targeting is approx. 122,500. In collaboration with the respective EDs, we estimate that this probably equates to 50,000-60,000 individual patients. We will conduct deep-dive analysis of ED records in order to verify this at the outset of this project. [Note: given the definition of 'actively engaged' in the Scale/Speed of Implementation section below, we have based our target population on the number of avoidable ED visits.]

With respect to our efforts to strengthen primary care presence in the neighborhoods and reach out to the local population with targeted educational efforts, these approaches will center specifically on the Northern/Central Forestland, Juniper Hill-Ash Park, and the Cedar Bay neighborhoods with a specific focus on the population of lower socioeconomic status.

d. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

PPS Response (Limited to 500 Words)
The resources required for this project are based on our strategy, which will consist of a multi-pronged approach that closely follows the DSRIP Toolkit guidance and addresses the need to co-locate primary care services with the ED, builds up primary care capabilities that can take over the current non-acute ED care and addresses the need to provide education to the current ED utilizers. 1. Physically locating PCMHSs adjacent to, or in our current EDs. This will involve relocation of 3 PCMH practices to the ED sites. In order to be maximally effective, the opening hours of the PCMH would be 24/7 just like the ER. From a cost perspective, however, we will most likely start with a PCMH location in the ED that is open during times that patient traffic to the ER Is highest. Generally this is between 7am and 9pm both week days and weekends. a. For two of our EDs, we are able to create space within the ED department that could accommodate the PCMH screening, treatment and waiting room areas. In these cases, we aim to create one physical entrance to the ED/PCMH which will enable us to set up a single workflow with effective triage that will direct patients to the ED or the PCHM office as appropriate. b. At one of our ED sites, the co-located service will need to be stationed on the floor above the ED due to space limitations. In this case, we will not be able to create one point of entry to both services. Instead, we will work with clear signs and educational posters to help direct patients that first present at the ED and are triaged to the PCMH to the correct location. 2. Developing protocols for triage and referral in compliance with EMTALA standards. Our goal is to have triage carried out by trained ED nurses that will 'admit' patients to the ER or refer to the PCMH office as appropriate. At the PCMH office, patients will receive a full primary care visit directly upon referral. 3. Installing care coordinator services and patient navigators in the relocated PCMH offices. This will enable us to register identified high utilizers with health homes or direct the patients to sign up with a PCP if they do not have one, thus providing them with an alternative point of access for their non-acute conditions as well as educating them on how to deal with the presentation of non-acute symptoms in the future. 4. Deploying educational outreach programs together with the community based organizations in the neighborhoods with particularly high utilization patterns and paying specific attention to the cultural sensitivities and linguistic needs of each neighborhood. We have partnered with Forestland Welcoming Center together with which we will set up appropriate educational materials for new immigrants to the area and give them direct access to PCP and care coordination services.

e. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

PPS Response (Limited to 300 Words)

Forestland's real and perceived lack of primary care providers is a challenge that cannot be easily mended by any strategy, given the training needed to educate new primary care providers, care coordinators and patient navigators or incentive payments needed to bring in talent. The proposed combined ED/outpatient centers can partially resolve this issue by providing a touchpoint between provider and patient to educate patients on the benefits of scheduling outpatient checkups. This can also partially optimize primary care provider schedules to maximize utilization.

On top of limited medical resources, with the sheer diversity of Forestland and the high number of new immigrants, improved cultural and language competency is considered essential, given the numerous languages spoken by the population as well as cultural variations that come along with it. While more culturally and linguistically competent specialists could potentially close gaps in care for immigrant groups and others who require care in languages other than English, it was recognized during our CNA that it would be difficult to identify and recruit providers representing all the relevant ethnic groups. However, supportive staff, which might be peers, community health workers, or health navigators were considered effective for addressing a range of language and cultural issues.

Lastly, an ongoing risk will be the unavoidable macro-environmental threat of pervasive under- and unemployment, which can contribute to poor nutrition, health, and education. Affected patients will be forced, or will believe themselves to be forced, to continue using the ED as their primary destination for medical treatments. While Forestland may not have the ability to significantly alter greater macro-environmental trends, Forestland has initiated an effort with the State to educate low-income families on nutritious diets on a small budget

f. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve an overlapping service area. If there are no other PPS within the same service area, then no response is required.

PPS Response (Limited to 300 Words)
Since no other PPS in the Forestland region is undertaking project 2.b.ii, no significant coordination activities are planned between Forestland Health and its adjacent PPSs.

2. <u>Scale of Implementation</u> (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information.

a. Please indicate the number of Emergency Departments which will contain co-located primary care services by the end of Demonstration Year (DY) 4, or sooner as applicable. This number should be entered in the table as *Total Committed*.

Project Scale	Total Committed
Emergency Departments which contain co-located primary care services	3

Please identify the number of committed providers who are a part of the local Safety Net.

Project Scale	Number of Committed That Are Safety Net Providers*	Number of Safety Net Providers*	Percent of Safety Net Providers (10 Points)
Primary Care Physicians	50	42	6
Hospitals	3	2	25
Clinics	10	4	10
Health Home/Care Management	2	2	60

**Based on Department of Health Safety Net Provider designation*

b. Please indicate the total expected volume of patients the PPS intends to engage throughout this project by the end of Demonstration Year (DY) 4. This will become the *Expected # of Actively Engaged Patients*. Patient scale is measured by the total number of patients that are expected to be actively engaged by the end of Demonstration Year 4

Patient Scale	Commitment
Targeted Population to Benefit from Project	**119,475**
Total Attributed Population	**422,500**
% of Total Attributed to Benefit from Project	**27%**

3. <u>Speed of Implementation/Patient Engagement</u> (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information.

a. Please indicate the Demonstration Year (DY) and Quarter by which all participating Emergency Departments which contain co-located primary care services will achieve project requirements. Project speed is measured by how fast all the project requirements for all chosen locations are met**.**

PPSs will be expected to meet these requirements for all of the providers, sites, or other categories of entities included in the PPS "total committed" scale metric, unless otherwise specified in the Domain 1 DSRIP Project Requirements Milestones and Metrics.

Project Implementation Speed	DY0 (Baseline)		DY1		DY2		DY3		DY 4	
	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4
All Project Requirements Achieved								X		

b. Please indicate the expected timeline for achieving 100% engagement of total expected number of actively engaged patients identified. For example, the PPS may indicate that 25% of patients will be actively engaged by the end of Demonstration Year (DY) 1, 50% by the end of DY2, and 100% by the end of DY 3.

Patient Engagement Speed	DY0 (Baseline)		DY1		DY2		DY3		DY 4	
	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4
Number of *Actively Engaged* Patients	23895	23895	47790	47790	71685	71685	95580	119475	119475	119475
Expected # of Actively Engaged Patients	119475	119475	119475	119475	119475	119475	119475	119475	119475	119475
% of Patients *Actively Engaged*	20%	20%	40%	40%	60%	60%	80%	100%	100%	100%

For this project, Actively Engaged is defined as number of participating patients who presented at the ED but were successfully and appropriately redirected to PCMH, after triage. Please note: It is expected that the baseline number of patients engaged in this project may be 0. If so, please indicate 0 in the Year 0 baseline column.

4. <u>Project Resource Needs and Other Initiatives</u> (750 word limit, Not Scored)

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
X	

If yes: Please describe why capital funding is necessary for the Project to be successful.

PPS Response (Limited to 375 Words)
Capital a budget funding will be necessary for a variety of costs. The primary need for capital funding will be to restructure our current 3 EDs to accommodate the PCHM services either within the ED space (2 locations) or near to it (1 location). In addition to the need for additional funding to change some of the existing infrastructure, we will require additional budget to develop and distribute education materials and start modest campaigns for patients, which will be made available to our patients.

b. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
X	

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Name of Entity	Medicaid/Other Initiative	Project Dates	Description of Initiatives
White Pine Medical Center	Budget Meals Outreach 2015	January 1st 2015 – December 31st 2015	Health navigators will be available near large retail/food outlets to provide pamphlets that will help shoppers plan cheap, nutritious, and filling meals.

a. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

PPS Response (Limited to 375 Words)
These existing projects, taken on by two of the PPS's provider hospitals, are supplemental to the PPS's own project, but much more limited in scope. The PPS's own project 2.b.ii targets a much larger population of Foreland's service area, as all patients who schedule outpatient appointments or use the ED are applicable.

5. <u>Domain 1 DSRIP Project Requirements Milestones & Metrics:</u>

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards completion of project requirements, scale of project implementation, and patient engagement progress in the project.

a. **Detailed Implementation Plan:** By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

b. **Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.

2.b.iv Care Transitions Intervention Model to Reduce 30-day Readmissions for Chronic Health Conditions

Project Objective: To provide a 30-day supported transition period after a hospitalization to ensure discharge directions are understood and implemented by the patients at high risk of readmission, particularly patients with cardiac, renal, diabetes, respiratory and/or behavioral health disorders.

Project Description: A significant cause of avoidable readmissions is non-compliance with discharge regiments. Non-compliance is a result of many factors including health literacy, language issues, and lack of engagement with the community health care system. Many of these can be addressed by a transition case manager or other qualified team member working one-on-one with the patient to identify the relevant factors and find solutions. The following components to meet the three main objectives of this project, 1) pre-discharge patient education, 2) care record transition to receiving practitioner, and 3) community-based support for the patient for a 30-day transition period post-hospitalization.
Additional resources for these projects can be found at www.caretransitions.org and http://innovation.cms.gov/initiatives/CCTP/.

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the document, **Domain 1 DSRIP Project Requirements Milestones and Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements.

1. Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.
2. Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.
3. Ensure required social services participate in the project.
4. Transition of care protocols will include early notification of planned discharges and the ability of the transition case manager to visit the patient while in the hospital to develop the transition of care services.
5. Establish protocols that include care record transitions with timely updates provided to the members' providers, particularly delivered to members' primary care provider.
6. Ensure that a 30-day transition of care period is established.
7. Use EHRs and other technical platforms to track all patients engaged in the project.

Partners Participating in this Project
Please list the name of the providers for this selected project along with identification numbers.

Provider Name	NPI
Forestland Hospital Center	1467645681

Project Response & Evaluation (Total Possible Points – 100):

1. Project Justification, Assets, Challenges, and Needed Resources (1500 word limit, Total Possible Points – 20)

a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design and sites included. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

PPS Response (Limited to 500 Words)
As seen in the community needs assessment (CNA) the leading causes of death and premature death in Forestland include a substantial number of chronic diseases including disease of the heart, cancer, diabetes, chronic lower respiratory disease, essential hypertension, HIV, mental and behavioral disorders. This lists points to a strong need to be more proactive in successfully managing chronic conditions in our community. The high number of potentially preventable inpatient admissions, emergency visits, and readmissions in Forestland, suggests that a care transitions intervention model to reduce 30 day readmissions for chronic health conditions is a critical project selection for the Forestland Health PPS. The majority of PQI admissions in Forestland are for chronic conditions. . In addition, despite having fewer potentially avoidable emergency room visits (PPV) per 100 Beneficiaries than NYS, the proportion of Emergency Visits that are considered potentially preventable is quite high: 74.5% for Forestland as a whole and ranging from 64.6% - 80.4% among zip code areas. Lack of access to and availability of community resources was clearly recognized by the community as having a significant impact on health and well-being. This observation is further supported by the data included in the CNA. In NYS, only 53% of Medicaid Managed Care beneficiaries who were prescribed antidepressant medications continued to use the medication for the entirety of the 12-week acute treatment phase, and only 37% remained on the medication for at least 6 months (QARR, 2012. Additionally, only 65% of adults enrolled in Medicaid Managed Care were hospitalized for a mental illness received a follow up within 7 days of discharge; 79% received a follow-up within 30 days (QARR, 2012). Finally, approximately 17% of Forestland's population are not US citizens. This figure likely underestimates the immigrant population in Forestland, because the number of undocumented individuals is substantial. Approximately 22.6 thousand people in Forestland are reported to have migrated to the United States less than one year ago, and approximately one in four people report speaking English less than "very well." Language issues are a driver of non-compliance, and may be especially so for our community. Those who are not US citizens and who speak English less than "very well" may experience additional regulatory or cultural barriers to health care access. Although bilingual providers and interpretation may be available for the largest language groups, smaller populations feel the burden of translation

and interpretation falls on them. Among the undocumented population, the concerns of other immigrant populations are further magnified. Access to most services is limited, and the fear of deportation results in lower utilization of services that are available, including health services. Providers report that people who are undocumented want to avoid providing information about themselves, and avoid "the system" to the greatest extent possible.

a. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population be specific and could be based on geography, disease type, demographics, social need or other criteria. This patient population that the PPS expects to actively engage over the course of the project will be a subset of the total attributed population.

PPS Response (Limited to 300 Words)

The target population for this project are patients with chronic conditions, and an assessed moderate to high risk of readmission who, as a result of this project, complete care transition plans within 30-days of discharge. In phase I, the transition project will focus on Dual eligibles. Nearly one in five Medicare patients discharged from a hospital—approximately 2.6 million seniors—is readmitted within 30 days, at a cost of over $26 billion every year. Approximately half (52%) of the Forestland older adult population of 290.7 thousand is dually eligible for Medicaid and Medicare. Forestland "duals" account for nearly one-third (32.3%) of all dually eligible individuals in GFL, and 17.7% in NYS. In Phase II, we will more comprehensively cover patients with the following diseases as supported by the need in our community and the highest rates of readmission Diabetes, Circulatory Diseases, and Respiratory Disease.

b. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

PPS Response (Limited to 500 Words)

The Care Transition Plan will build on existing successes from a pilot project that offered ED services, target specifically at the chronically street homeless. This population group tends to have severe alcohol dependence and/or co-occurring disorders, and therefore its members are particularly high users of emergency departments. Many have multiple visits in a single day to shelters and other community resources. As we expand the transition program beyond the homeless population in the ED, we will need to supplement our navigator team with additional resources and additional training.

To be successful, we must address the uneven and inconsistent distribution and access of primary care providers in Forestland. Their capacity, quality, linkages to broader health care delivery systems, and operating hours may not be sufficient in some high need areas. Additionally, they likely lack culturally and linguistically competent specialists. In order to successfully transition care effectively out of the hospital setting, we must strengthen this capacity in the community. Doing so will be a central part of our Cultural Competency and Health Literacy Strategy (section 7). Likewise, the data suggest more

resources are needed to equip community based organizations with staff and capability, including a structured and adequate funding stream for case managers, navigators, counselors, health educators and/or community health workers placed at CBOs or in the field. These staff will be critical if the Care Transition Program is to be successful. Specifically, 25% of the hospital staff no longer needed due to the decreased hospital capacity resulting from participation in the DSRIP program will be repurposed to managing care transitions for patients with chronic conditions. Particular focus will be put to retraining nurses to apply their clinical competencies to patients while they are in the community, to avoid potentially preventable readmissions.

To ensure that the Care transition program is focused on the full care delivery system, the Forestland Health PPS will convene a project team that involves critical care and community based organizations. These will include long term care facilities, health homes with demonstrated experience in care pathways; Medicaid managed care organizations, hospice, home medical equipment providers, Programs of All-Inclusive Care for the Elderly (PACE) providers, and current navigator teams across all partnering organizations to establish discharge planning protocols that begin at the moment of admission and continue through to the placement of the patients in their home setting. This PPS network-wide approach will allow the Transition program to draw on the success and experience of the previously mentioned organizations, as well as establish protocols for assessments, early notifications of discharges, care record transitions, and the use of the HealthInsight IT platform – recently implemented at the Forestland Hospital Center Health Home, which will be rolled out throughout the PPS as part of Project 2.a.i. – to enhance communication across all members of the care and transitions teams.

c. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

PPS Response (Limited to 300 Words)

There is clear recognition of the impact that poverty and lack of community resources have on health and well-being. Low-income Forestland residents describe very stressful lives, with concerns that include, but are not limited to, employment, housing (which is in increasingly short supply with the gentrification of many Forestland neighborhoods), safety, access to healthy food, and appropriate resources for children. These factors, along with others, will continue to play a role in the health choices and compliance of patients. Strengthening community based organizations and providing on-going support to patients through navigators will help to connect community members to available resources and support them in taking advantage of those resources. Specifically, CBOs that are already operating in high-need neighborhoods will receive increased support from the PPS, both in form of financial aid to expand their activities, and through repurposed staff to provide additional capacity and to lend their clinical expertise.

Without a robust data and information sharing platform, coordination across the delivery system will remain disjointed and transitioning care to receiving practitioner in a timely manner will be very

difficult. In addition, an interoperable information technology system with robust analytics will be critical in helping us to identify those patients in greatest need of care transition services. This level of sophisticated data analytics will not only allow drill down into high utilizing patients, but also help predict some patient behavior and permit early intervention. To be most effective, we hope to use the analytic capabilities to perform specific analysis of the volume of ER visits, admissions and readmissions for each target diagnosis. We anticipate investing in a population health management system to help address the information sharing and data needs of our PPS.

d. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve an overlapping service area. If there are no other PPS within the same service area, then no response is required.

PPS Response (Limited to 300 Words)

Forestland Health is the largest PPS in Forestland, and therefore is attributed the greatest portion of Medicaid beneficiaries living with chronic conditions. Since patient access patterns across each of the Forestland PPSs are distinct, there will be little overlap in Care Transition Management Plans. Coordination across PPSs will consist of sharing experiences and best practices in care transitions, but there will be no patient or clinical coordination.

2. <u>Scale of Implementation</u> (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information.

a. Please indicate the total number of sites, programs and/or providers the PPS intends to include in the project by the end of Demonstration Year (DY), or sooner as applicable. These numbers should be entered in the table as *Total Committed*.

Project Scale	Total Committed (10 Points)	Number in Network
Primary Care Physicians	30	2000
Non-PCP Practitioners	20	50
Hospitals	3	3
Health Home/Care Management	2	2
Community Based Organizations	5	35
All Other	5	60

Please identify the number of committed providers who are a part of the local Safety Net.

Project Scale	Number of Committed That Are Safety Net Providers*	Number of Safety Net Providers*	Percent of Safety Net Providers (10 Points)
Primary Care Physicians	20	700	3
Non-PCP Practitioners	10	60	17
Hospitals	3	3	38
Health Home/Care Management	2	10	20
Community Based Organizations	0	0	0
All Other	0	0	0

**Based on Department of Health Safety Net Provider designation*

b. Please indicate the total expected volume of patients the PPS intends to engage throughout this project by the end of Demonstration Year (DY) 4. This will become the *Expected # of Actively Engaged Patients*. Patient scale is measured by the total number of patients that are expected to be actively engaged by the end of Demonstration Year 4.

Patient Scale	Commitment
Targeted Population to Benefit from Project	231,530
Total Attributed Population	422,500
% of Total Attributed to Benefit from Project	54.8%

3. <u>Speed of Implementation/Patient Engagement</u> (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information.

a. Please indicate the Demonstration Year (DY) and Quarter by which all participating hospitals will achieve project requirements. Project speed is measured by how fast all the project requirements for all chosen locations are met**.**

PPSs will be expected to meet these requirements for all of the providers, sites, or other categories of entities included in the PPS "total committed" scale metric, unless otherwise specified in the Domain 1 DSRIP Project Requirements Milestones and Metrics.

Project Implementation Speed	DY0 (Baseline)		DY1		DY2		DY3		DY 4	
	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4
All Project Requirements Achieved						✔				

b. Please indicate the expected timeline for achieving 100% engagement of total expected number of actively engaged patients identified. For example, the PPS may indicate that 25% of patients will be actively engaged by the end of Demonstration Year (DY) 1, 50% by the end of DY2, and 100% by the end of DY 3.

Patient Engagement Speed	DY0 (Baseline)		DY1		DY2		DY3		DY 4	
	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4
Number of *Actively Engaged* Patients	0	0	57,883	57,883	115,765	115,765	173,647	173,647	231,530	231,530
Expected # of Actively Engaged Patients	231,530	231,530	231,530	231,530	231,530	231,530	231,530	231,530	231,530	231,530
% of Patients *Actively Engaged*	0%	0%	25%	25%	50%	50%	75%	75%	100%	100%

For this project, Actively Engaged is defined as the number of participating patients with a care transition plan developed prior to discharge who are not readmitted within that 30-day period. Please note: It is expected that the baseline number of patients engaged in this project may be 0. If so, please indicate 0 in the Year 0 baseline column.

4. Project Resource Needs and Other Initiatives (750 word limit, Not Scored)

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
X	

If yes: Please describe why capital funding is necessary for the Project to be successful.

PPS Response (Limited to 375 Words)
Yes- Capital funding is being requested for a Population Health Management system which will be leveraged for this project. This will include an interoperable EHR system which can collect, aggregate, analyze and communicate patient and population level data across the care continuum. This system (or a compatible additional system) needs to have robust individual and population level clinical

analytics and reporting capabilities including the ability to track and trend patient outcomes and health status across the care continuum.

b. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
	X

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Name of Entity	Medicaid/Other Initiative	Project Dates	Description of Initiatives

c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

PPS Response (Limited to 375 Words)

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards completion of project requirements, scale of project implementation, and patient engagement progress in the project.

a. **Detailed Implementation Plan:** By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

b. **Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.

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

In order to be eligible for this project, a PPS must already be pursuing 10 projects, demonstrate its network capacity to handle an 11th project, and evaluate that the network is in a position to serve uninsured (UI), non-utilizing (NU), and low utilizing (LU) populations. Any public hospital in a specified region has first right of refusal for implementing this 11th project. Only the uninsured, non-utilizing, low-utilizing Medicaid member populations will be attributed to this project. Finally, in order to participate in pay-for-reporting outcome metrics in Demonstration Years (DY) 4 and 5, the PPS will submit data as specified.

Project Objective: The objective of this 11th project is to address Patient Activation Measures® (PAM®) so that UI, NU, and LU populations are impacted by DSRIP PPS' projects. Feedback from the public comment period resulted in the state to include UI members in DSRIP, so that this population benefits from a transformed healthcare delivery system. Please refer to the body of literature found below on patient activation and engagement, health literacy, and practices to reduce health care disparities:

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1955271/
http://content.healthaffairs.org/content/32/2/223.full
http://www.hrsa.gov/publichealth/healthliteracy/
http://www.health.gov/communication/literacy/
http://www.ama-assn.org/ama/pub/about-ama/ama-foundation/our-programs/public-health/health-literacy-program.page
http://www.hrsa.gov/culturalcompetence/index.html
http://www.nih.gov/clearcommunication/culturalcompetency.htm

Project Description: This project is focused on persons not utilizing the health care system and works to engage and activate those individuals to utilize primary and preventive care services. The PPS will be required to formally train on PAM®, along with baselining and regularly updating assessments of communities and individual patients. This project encapsulates three primary concepts, which drive the requirements for this project:

- Patient activation
- Financially accessible health care resources
- Partnerships with primary and preventive care services

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the document, **Domain 1 DSRIP Project Requirements Milestones and Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements.

1. Contract or partner with community-based organizations (CBOs) to engage target populations using PAM® and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.
2. Establish a PPS-wide training team, comprised of members with training in PAM® and expertise in patient activation and engagement.

3. Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.
4. Survey the targeted population about healthcare needs in the PPS' region.
5. Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.
6. Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10).
    - This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member.
    - Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.
7. Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM® during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.
8. Include beneficiaries in development team to promote preventive care.
9. Measure PAM® components, including:
    - Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service.
    - If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM® survey and designate a PAM® score.
        - Individual member score must be averaged to calculate a baseline measure for that year's cohort.
        - The cohort must be followed for the entirety of the DSRIP program.
    - On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation.
    - If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP.
        - The PPS will NOT be responsible for assessing the patient via PAM® survey.
        - PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes.
    - Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.
10. Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.
11. Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage community health care resources (including for primary and preventive services) and patient education.

12. Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.
13. Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM®.
14. Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive health care services and resources.
15. Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.
16. Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.
17. Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.

Partners Participating in this Project

Please list the name of the providers for this selected project along with identification numbers.

Provider Name	NPI
Forestland Hospital Center	1467645681

Project Response & Evaluation (Total Possible Points – 100):

1. <u>Project Justification, Assets, Challenges, and Needed Resources</u> (1500 word limit, Total Possible Points – 20)

a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. The project description should consider three primary activation concepts: *patient activation*, *financially accessible health care resources*, and *partnerships with primary and preventive care services.*

PPS Response (Limited to 500 Words)
Project 2.d.i will play a central role in achieving a reduction in avoidable ER visits and admissions for the providers in Forestland PPS – and, consequently, achieving the DSRIP goal of a 25% reduction in avoidable hospital use – because of the close link between poor access to / understanding of health services and reliance on the ER as a source for all care needs. This project will: - Pro-actively engage individuals who have little or no contact with the health system and who consequently often rely on the ER – whether uninsured or low/non-utilizers; - Empower and educate them about the most effective ways to access services; - Integrate them into primary care, preventive and community-based services, and work with these services to ensure active engagement.

These individuals typically do not access any primary or preventive care; many postpone care when needed or, when acute, rely on the ER. One individual in Birchview stated, "I go to the emergency room… That's where everybody has to go if you don't have health insurance."

According to WAM Primary Data Collection, Forestland also has a large number of undocumented uninsured. These individuals present a particular challenge in terms of engagement and activation as they are likely to avoid accessing services until absolutely necessary and are likely to be reluctant to register in any programs or offer personal information for fear of deportation (CNA).

Nearly 23,000 Forestland residents migrated to the US less than one year ago. According to our CNA they face additional regulatory and cultural barriers to accessing healthcare and are likely, as a result, to be low- or non-utilizers of the full range of primary and preventive health services.

Our cultural competency and health literacy strategy (Section 7) will clearly play an important role in achieving the goals of this project by creating a delivery system and a workforce that supports those with low health literacy and is more accessible to non-English-speakers.

A lack of understanding of the health system and poor health literacy is one of the key drivers of low/non-utilization. Another barrier that drives some individuals to be low/non-utilizers of preventive and primary care is the perceived high cost of co-payment and ongoing treatment.

The fragmentation of the current provider system – especially primary care – is another important driver of low/non-utilization and reliance on emergency services, as members expect to have to pay repeat visits to primary care physicians, or be sent from one service to another. This is a particular issue for the uninsured as they will bear the costs of any doubling up (e.g. unnecessary repeat tests / visits due to poor coordination and communication). The impact of this is not just over-stretched ERs but also chronic conditions that are left unmanaged and conditions that are undetected due to a lack of screening

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population be specific and could be based on geography, disease type, demographics, social need or other criteria. This patient population that the PPS expects to actively engage over the course of the project will be a subset of the total attributed population. Note: Only the uninsured, non-utilizing, low-utilizing Medicaid member populations will be attributed to this project.

PPS Response (Limited to 300 Words)

There are 344,000 documented uninsured individuals in Forestland. This includes individuals who are employed but who cannot afford private insurance and do not receive employer-provided insurance. Many choose not to purchase health insurance due to the high cost and their current good health;

there are also individuals who are unemployed but whose assets prevent them from being Medicaid-eligible.

Initial attribution results have demonstrated that there are 390,000 low/non-utilizers in Forestland, of which our State-set portion would be 234,000.* (This results in a total target population for this project of 628,000.)

c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. Please demonstrate that the PPS has network capacity to handle an 11th project and how the PPS is in a position to serve these UI, NU and LU populations. In addition, identify any needed community resources to be developed or repurposed.

PPS Response (Limited to 500 Words)

We have conducted an assessment of our capacity to deliver this 11th Project, both in terms of management capacity in the Executive body and committees of the PPS; and in terms of the management and front-line capacity at PPS provider organizations and local CBOs.

Forestland Hospital Center, the PPS Lead, has a strong track record of designing and delivering innovative models of care in collaboration with local partner organizations.

The Community Initiatives Committee, reporting to the PPS Executive Body (see Section 2 – Governance), will ensure that this project remains a priority for the PPS leadership and that it enjoys continued, dedicated attention at the most senior levels within the Forestland PPS governance structure.

The Community Initiatives Committee will also oversee our cultural competency and health literacy strategy (See Section 7), thereby ensuring that these initiatives are aligned with and complementary to this project.

Implementing this project will draw on resources that are expanded or established under other DSRIP projects. The expanded PCMHs and the premium APCs created under Project 2.a.i. (which will provide 'one-stop' care) and the community care workers described under Project 4.b.ii. (the number of which will be increased) will support the delivery of this project.

d. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

PPS Response (Limited to 300 Words)
The financial burden caused by offering the community care workers' time free of charge to the low/non-utilizers and uninsured creates a risk that providers will encourage community care workers to de-prioritize this work (since patient activation will be only one part of their role). We will ensure strict allocation of DSRIP budgets to these providers for this purpose. In addition, the publication of PCP-level performance in improving PAM scores will stimulate the PCPs to become more active, as will the inclusion of specific goals in community care workers' job plans and a defined percentage of their time being allocated to this work.

e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve an overlapping service area. If there are no other PPS within the same service area, then no response is required.

PPS Response (Limited to 300 Words)
No coordination activities are planned as no other PPS in our service area is taking project 2.d.i

2. <u>Scale of Implementation</u> (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information:

a. Please indicate the total number of individuals trained in PAM® or other patient activation techniques the PPS intends to include in the project by the end of Demonstration Year (DY) 4, or sooner as applicable. This number should be entered in the table as *Total Committed*.

Project Scale	Total Committed
Expected # of individuals trained in PAM® or other patient activation techniques	70

Please identify the number of committed providers who are a part of the local Safety Net.

Project Scale	Number of Committed That Are Safety Net Providers*	Number of Safety Net Providers*	Percent of Safety Net Providers (10 Points)
Primary Care Physicians	45	35	5
Non-PCP Practitioners	22	13	30
Hospitals	3	2	25
Clinics	10	9	21
Pharmacy	10	4	20
Community Based Organizations	20	0	0
All Other	5	0	0

**Based on Department of Health Safety Net Provider designation*

b. Please indicate the total expected volume of uninsured (UI), non-utilizer (NU) and low utilizer (LU) populations PPS intends to actively engage and provide services to through this project by the end of Demonstration Year (DY) 4. This will become the *Expected # of Actively Engaged Patients*. Patient scale is measured by the total number of patients that are expected to be actively engaged by the end of Demonstration Year 4

Patient Scale	Commitment
Target Uninsured Population to Benefit from the Project	394,000
Target Non-Utilizer Population to Benefit from the Project	93,600
Target Low Utilizer Population to Benefit from the Project	140,400

3. <u>Speed of Implementation/Patient Engagement</u> (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information.

a. Please indicate the Demonstration Year (DY) and Quarter by which all participating individuals trained in PAM® or other patient activation techniques will achieve project requirements. Project speed is measured by how fast all the project requirements for all chosen locations are met**.**

PPSs will be expected to meet these requirements for all of the providers, sites, or other categories of entities included in the PPS "total committed" scale metric, unless otherwise specified in the Domain 1 DSRIP Project Requirements Milestones and Metrics.

Project Implementation Speed	DY0 (Baseline)		DY1		DY2		DY3		DY 4	
	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4
All Project Requirements Achieved					X					

b. Please indicate the expected timeline for achieving 100% engagement of total expected number of actively engaged patients identified. For example, the PPS may indicate that 25% of patients will be actively engaged by the end of Demonstration Year (DY) 1, 50% by the end of DY2, and 100% by the end of DY 3.

Patient Engagement Speed	DY0 (Baseline)		DY1		DY2		DY3		DY 4	
	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4
Number of *Actively Engaged* Patients	0	0	30	60	120	190	260	320	380	440
Expected # of Actively Engaged Patients	628k	628k	628k	628k	628k	628k	628k	628k	628k	628k
% of Patients *Actively Engaged*	0	0	5	10	19	30	41	51	61	70

For this project, Actively Engaged is defined as the number of individuals who completed PAM® or other patient engagement techniques.

Please note: It is expected that the baseline number of patients engaged in this project may be 0. If so, please indicate 0 in the Year 0 baseline column.

4. <u>Project Resource Needs and Other Initiatives</u> (750 word limit, Not Scored)

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
	X

If yes: Please describe why capital funding is necessary for the Project to be successful.

PPS Response (Limited to 375 Words)

b. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
	X

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Name of Entity	Medicaid/Other Initiative	Project Dates	Description of Initiatives

c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

PPS Response (Limited to 375 Words)

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards scale of project implementation, completion of project requirements and patient engagement progress in the project.

a. Detailed Implementation Plan: By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

b. Quarterly Reports: PPS will submit quarterly reports on progress towards achievement of project requirements as defined in **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Quarterly reports to the Independent Assessor will include project status and challenges as well

as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.

3.a.i Integration of Primary Care and Behavioral Health Services

Project Objective: Integration of mental health and substance abuse with primary care services to ensure coordination of care for both services.

Project Description: Integration of behavioral health and primary care services can serve 1) to identify behavioral health diagnoses early, allowing rapid treatment, 2) to ensure treatments for medical and behavioral health conditions are compatible and do not cause adverse effects, and 3) to de-stigmatize treatment for behavioral health diagnoses. Care for all conditions delivered under one roof by known healthcare providers is the goal of this project.

The project goal can be achieved by 1) integration of behavioral health specialists into primary care clinics using the collaborative care model and supporting the PCMH model, or 2) integration of primary care services into established behavioral health sites such as clinics and Crisis Centers. When onsite coordination is not possible, then in model 3) behavioral health specialists can be incorporated into primary care coordination teams (see project IMPACT described below).

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the attachment: **Domain 1 DSRIP Project Requirements Milestones & Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements.

There are three project areas outlined in the list below. Performing Provider Systems (PPSs) may implement one, two, or all three of the initiatives if they are supported by the Community Needs Assessment.
Any PPS undertaking one of these projects is recommended to review the resources available at http://www.integration.samhsa.gov/integrated-care-models.

A. *PCMH Service Site:*
   1. Co-locate behavioral health services at primary care practice sites. All participating primary care providers must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by Demonstration Year (DY) 3.
   2. Develop collaborative evidence-based standards of care including medication management and care engagement process.
   3. Conduct preventive care screenings, including behavioral health screenings (PHQ-9, SBIRT) implemented for all patients to identify unmet needs.
   4. Use EHRs or other technical platforms to track all patients engaged in this project.

B. *Behavioral Health Service Site:*
   1. Co-locate primary care services at behavioral health sites.
   2. Develop collaborative evidence-based standards of care including medication management and care engagement process.

3. Conduct preventive care screenings, including behavioral health screenings (PHQ-9, SBIRT) implemented for all patients to identify unmet needs.
4. Use EHRs or other technical platforms to track all patients engaged in this project.

C. *IMPACT:* This is an integration project based on the Improving Mood - Providing Access to Collaborative Treatment (IMPACT) model. IMPACT Model requirements include:
1. Implement IMPACT Model at Primary Care Sites.
2. Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.
3. Employ a trained Depression Care Manager meeting requirements of the IMPACT model.
4. Designate a Psychiatrist meeting requirements of the IMPACT Model.
5. Measure outcomes as required in the IMPACT Model.
6. Provide "stepped care" as required by the IMPACT Model.
7. Use EHRs or other technical platforms to track all patients engaged in this project.

Partners Participating in this Project
Please list the name of the providers for this selected project along with identification numbers.

Provider Name	NPI
Forestland Hospital Center	1467645681

Project Response & Evaluation (Total Possible Points – 100):

2. <u>Project Justification, Assets, Challenges, and Needed Resources</u> (1400 word limit, Total Possible Points – 20)

a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design and sites included. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

PPS Response (Limited to 400 Words)
Forestland Performing Provider System (FPPS) serves a population of 2.5 million with almost half covered by Medicaid (MA). Another 14% are uninsured amounting to an MA and uninsured population that exceeds 60%. FPPS's health needs are served by 3 general hospital systems, 16 ambulatory surgical centers, 19 federally qualified health centers, and community based primary care and specialty physicians. Behavioral health resources include one specialty psychiatric hospital wing with 140 inpatient beds and 790 inpatient psychiatric beds based in the general hospitals. In 2012, the MA program incurred $234 million for behavioral health services, with about 60% going for inpatient services.

In Forestland, behavioral health disorders are fairly common. In 2012, 17.7% of MA beneficiaries received behavioral health related services, including pharmacy, with the largest number concentrated in North/Central Forestland and Juniper Hill-Ash Park. About 50% of Forestland behavioral health visits are with primary care providers and about 70% of psychotropic medications are prescribed by non-psychiatric physicians. This creates the high likelihood that FPPS MA patients' behavioral health conditions are being over-treated, under treated, or mistreated leading less than optimal care. Numerous studies have shown that approaching a patient with a treatment system that utilizes coordinated holistic methods of care, is more desirable and leads to a healthier population.

b. Please define the patient population you expect to engage through the implementation of this project. The definition of patient population be specific and could be based on geography, disease type, demographics, social need or other criteria. This patient population that the PPS expects to actively engage over the course of the project will be a subset of the total attributed population.

PPS Response (Limited to 200 Words)

The target population for this project includes MA patients with behavior health conditions being seen by the participating FPPS practices, but will ultimately include the entire MA population . The goal of this project is to foster care under one roof by known healthcare providers.

c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

PPS Response (Limited to 400 Words)

The three initiatives that FPPS will undertake simultaneously are described briefly below, in which the resources required to complete the project are identified:

A. Co-locate behavioral services at primary care practice sites

Three of the largest primary care group practices and two of the 19 Federally Qualified Health Centers (FQHC) agreed to participate in this project and have begun the process to become a National Committee for Quality Assurance (NCQA) level 3 Patient Centered Medical Home (PCMH) or Advanced Primary Care (APC) model. These sites have agreed to implement the IMPACT program. Some resources to expand and/or modify the physical facilities will be required to accommodate the addition of behavioral health providers at each participating site. Additionally, some upgrades in the electronic health record (EHR) systems will be required to accommodate the behavioral health records with special attention to the added levels of confidentiality associated with behavioral health services.

B. Co-locate primary care services at behavioral health sites

Focused behavioral health programs and services in Forestland include:

- 536 general psychiatrists
- 93 Outpatient programs
- A state run psychiatric hospital with 140 inpatient beds
- 790 psychiatric beds located in general hospitals
- 186 mental health residential programs
- 71 mental health support programs
- 21 targeted case management programs
- 100 youth programs

There are two psychiatric group practices affiliated with FPPS that have 15+providers including psychiatrists, psychologists, and social workers. While there is collaboration between the behavioral health programs and primary care providers it is informal and not integrated. As mentioned earlier, more than half of MA patients have a physical co-morbid condition, especially cardiac and cancer. While some patients already have a pre-existing relationship with a primary care provider, those that do not will be made aware of the opportunity to get their primary care services from the on-site primary care provider.

C. Implement Improving Mood – Providing Access to Collaborative Treatment (IMPACT)

IMPACT is a program of the University of Washington and is a way to support the behavioral health needs of primary care patients. In a larger sense, patients who are not comfortable going to a behavioral health provider tend to trust their primary care provider and may be more willing to accept services to treat and support their behavioral health needs. The key elements of the IMPACT approach include:

1. Collaborative care
2. Depression Care Manager On-site
3. Designated Psychiatrist (not necessarily on site)
4. Outcome measurement
5. Stepped care

d. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

PPS Response (Limited to 200 Words)

There are a multitude of challenges to achieve the goals of this project ranging from social stigmas to seeking behavioral health services and lack of primary care provider support. Yet, ignoring those with serious behavioral health conditions leads to greater risk of developing co-morbid illnesses and chronic diseases, and generates disproportionate costs for the MA program. These challenges will be met by working with identified progressive providers who understand the value of integrating primary care and behavioral health who will serve as a model to leverage throughout the FPPS service area.

e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve overlapping service areas. If there are no other PPSs within the same service area, then no response is required.

PPS Response (Limited to 200 Words)
Since no adjacent PPSs in the Forestland service area are undertaking project 3.a.i, no coordination activities were planned for this project.

3. <u>Scale of Implementation</u> (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information:.

a. Please indicate the total number of PCP sites, behavioral health provider sites, substance abuse provider sites, and all other sites the PPS intends to include in the project by the end of Demonstration Year (DY) 4, or sooner as applicable. This number should be entered in the table as *Total Committed*.

Project Scale	Number Committed	Number of Safety Net Providers*	Percent of Safety Net Providers
Expected # of PCPs	50	20	3%
Expected # of Behavioral Health Sites	2	2	7%
Expected # of Substance Abuse Sites	2	2	20%
Expected # of All Other Provider Sites	5	3	30%

**Based on Department of Health Safety Net Provider designation*

b. Please indicate the total expected volume of patients the PPS intends to target throughout this project by the end of Demonstration Year (DY) 4.

Patient Scale	Commitment
Targeted Population to Benefit from Project	139,425
Total Attributed Population	422,500
% of Total Attributed to Benefit from Project	33%

4. <u>Speed of Implementation/Patient Engagement</u> (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and impact

on the target population will receive more funding than those taking longer to meet goals. In order to assess speed and patient engagement, please complete the following information.

a. Please indicate the Demonstration Year (DY) and Quarter by which all sites participating in the project will meet all project requirements.

Project Implementation Speed	DY0 (Baseline)		DY1		DY2		DY3		DY 4	
	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4
All Project Requirements Achieved									X	

b. Please indicate the expected timeline for engagement of patients within the project. For example, the PPS may indicate that 25% of targeted patients will be *actively engaged* by the end of Demonstration Year (DY) 1, 50% by the end of Demonstration Year (DY) 2, etc.

Patient Engagement Speed	DY0 (Baseline)		DY1		DY2		DY3		DY 4	
	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4
Expected # of *Actively Engaged* Patients	27885	27885	55770	55770	83655	83655	111540	111540	139425	139425
Targeted Population	139425	139425	139425	139425	139425	139425	139425	139425	139425	139425
% of Patients that are *Actively Engaged*	20	20	40	40	60	60	80	80	100	100

**For this project, Actively Engaged is defined as the total of number of patients engaged per each of the three models in this project, including:*

A. PCMH Service Site: Number of patients screened (PHQ-9 / SBIRT)

B. Behavioral Health Site: Number of patients receiving primary care services at a participating mental health or substance abuse site.

C. IMPACT: Number of patients screened (PHQ-9 / SBIRT)

Please note: It is expected that the baseline number of patients engaged in this project may be 0. If so, please indicate 0 in the Year 0 baseline column.

5. <u>Project Resource Needs and Other Initiatives</u> (750 word limit, Not Scored)

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No

X	

If yes: Please describe why capital funding is necessary for the Project to be successful.

PPS Response (Limited to 375 Words)
Capital budget funding is required for renovation of the demonstration site facilities and upgrades to the IT EHR systems to accommodate the additional staff and to facility care coordination. Capital requirement estimates will be developed in conjunction with the FPPS facilities and IT staff.

b. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
X	

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Name of Entity	Medicaid/Other Initiative	Project Dates	Description of Initiatives
Several entities	Medicaid P4P	2012-2020	quality improvement based on the behavioral health related HEDIS (Healthcare Effectiveness Data and Information Set) measures

c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

PPS Response (Limited to 375 Words)
Several primary care practices are in involved in the Medicaid Pay for Performance initiative (Medicaid P4P). Under this program, that has been in place for the past several years, these practices have shown significant quality improvement based on the behavioral health related HEDIS (Healthcare Effectiveness Data and Information Set) measures, including antipsychotic medication management, diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications, cardiovascular monitoring for people with cardiovascular disease and schizophrenia, adherence to antipsychotic medications for individuals with schizophrenia, and initiation and engagement of alcohol and other drug dependence treatment.

The Medicaid P4P program that is in place will be enhanced by the proposed DSRIP project that is focused on integration of primary care and behavioral health. It is likely that with the use of the enhanced screening efforts, more people will receive appropriate high quality care.

6. Domain 1 DSRIP Project Requirements Milestones & Metrics:

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards completion of project requirements, scale of project implementation, and patient engagement progress in the project.

c. Detailed Implementation Plan: By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

d. Quarterly Reports: PPS will submit quarterly reports on progress towards achievement of project requirements as defined in Domain 1 DSRIP Project Requirements Milestones & Metrics. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.

3.a.ii Behavioral Health Community Crisis Stabilization Services

Project Objective: To provide readily accessible behavioral health crisis services that will allow access to appropriate level of service and providers, supporting a rapid de-escalation of the crisis.

Project Description: Routine emergency departments and community behavioral health providers are often unable to readily find resources for the acutely psychotic or otherwise unstable behavioral health patient. This project entails providing readily accessible behavioral health crisis services that will allow access to appropriate level of service and providers, supporting a rapid de-escalation of the crisis. The Behavioral Health Crisis Stabilization Service provides a single source of specialty expert care management for these complex patients for observation monitoring in a safe location and ready access to inpatient psychiatric stabilization if short term monitoring does not resolve the crisis. A mobile crisis team extension of this service will assist with moving patients safely from the community to the services and do community follow-up after stabilization to ensure continued wellness.

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the attachment: **Domain 1 DSRIP Project Requirements Milestones & Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements.

1. Implement a crisis intervention program that, at a minimum, includes outreach, mobile crisis, and intensive crisis services.
2. Establish clear linkages with Health Homes, ER and hospital services to develop and implement protocols for diversion of patients from emergency room and inpatient services.
3. Establish agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.
4. Develop written treatment protocols with consensus from participating providers and facilities.
5. Include at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services; expansion of access to specialty psychiatric and crisis-oriented services.
6. Expand access to observation unit within hospital outpatient or at an off campus crisis residence for stabilization monitoring services (up to 48 hours).
7. Deploy mobile crisis team(s) to provide crisis stabilization services using evidence-based protocols developed by medical staff.
8. Ensure that all PPS safety net providers are actively connected EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.
9. Establish central triage service with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers.
10. Ensure quality committee is established for oversight and surveillance of compliance with protocols and quality of care.
11. Use EHRs or other technical platforms to track all patients engaged in this project.

Partners Participating in this Project

Please list the name of the providers for this selected project along with identification numbers.

Provider Name	NPI
Forestland Hospital Center	1467645681

Project Response & Evaluation (Total Possible Points – 100):

1. **<u>Project Justification, Assets, Challenges, and Needed Resources</u> (1000 word limit, Total Possible Points – 20)**

   a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design and sites included. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

PPS Response (Limited to 400 Words)
Forestland Performing Provider System (FPPS) serves an attributed Medicaid population of 422,500. Within Forestland as a whole around 14% of residents are uninsured amounting to an MA and uninsured population that exceeds 60%. Forestland health needs are served by 14 general hospital systems – of which 3 are in Forestland PPS - 16 ambulatory surgical centers, 19 federally qualified health centers, and community based primary care and specialty physicians. Behavioral health resources include one specialty psychiatric hospital wing with 140 inpatient beds and 790 inpatient psychiatric beds based in the general hospitals. In 2012, the MA program incurred $234 million for behavioral health services, with about 60% going for inpatient services. Currently, there are 3 general hospitals that are part of the Forestland PPS (FPPS). Each of these hospitals have emergency services, however most are ill prepared to deal effectively with psychiatric emergencies. When confronted with an out-of-control patient that is experiencing a psychiatric crisis, the whole Emergency Department is disrupted and all patients seeking medical emergency care are affected. Additionally, when a person is experiencing a psychiatric crisis in the community, the police are usually called in to respond to the situation. While policemen are provided some training in handling these situations, they often are not sure where to seek help other than to call an ambulance to transport the individual to a hospital. This is not the best way to deal with the situation. This project is intended to improve the crisis intervention, stabilization, and treatment of Forestland residents. The project will foster a collaborative working relationship between the police, ambulance transport companies, general hospital emergency rooms, and the existing behavioral health resources. Two or three mobile crisis teams will be added to the existing resources to respond to a crisis within 2 to 4 hours, unless the patient is in immediate danger to him/herself or others, in which case the patient will be transported immediately to a designated hospital or a crisis center. The crisis teams will concentrate on the neighborhoods that experience the most serious psychological distress, specifically Juniper Hill, Plum Ridge/Cherryburst, and Redwood Summit.

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population be specific and could be based on geography, disease type, demographics, social need or other criteria. This patient population that the PPS expects to actively engage over the course of the project will be a subset of the total attributed population.

PPS Response (Limited to 200 Words)
Embedded in the service array for behavioral health services is a Comprehensive Psychiatric Emergency Program that served 1,572 individuals in 2012 according to OMH. These individuals experienced a severe psychiatric emergency that required immediate intervention and stabilization. While these statistics include those that were reported to OMH, many more psychiatric emergencies occurred that went unreported. Given an MA population of 1.2 million, it is likely that the number of individuals experiencing a psychiatric crisis of a less disruptive nature is significantly higher. (Note 1)

c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

PPS Response (Limited to 400 Words)

The major resources that will be included for the FPPS Crisis Stabilization System include:

1. Crisis stabilization
   Program has:
   - An observation unit within a hospital outpatient facility or an off campus crisis residence for up to 48 hours of monitoring
   - Capacity to accommodate transitional age youth : 18-24 years old
   - Policies and procedures that invest up front in comprehensive and/or non-traditional services for individuals in crisis who may not have been through the mental health or substance disorder treatment systems (i.e. “failed” at everything else)

2. Short and longer-teRm respite
   Program can:
   - Accommodate respite stays for up to 14 days, per 1915i requirements
   - Include, train and support clinical, non-clinical, and peer staff (specifically trained in peer intervention models such as Open Dialogues and Intentional Peer Support) who are able to deliver or refer to traditional and non-traditional treatment models (including non-withdrawal substance use disorder stabilization services)
   - Support transitional age youth and properly refer youth under 18 to like-services (e.g., form agreements with OMH-programs, such as NYC Children’s Center,)
   - Form partnerships and linkage agreements with hospitals and emergency services to facilitate diversion agreements and make referrals

3. Mobile crisis TEAMS

Program has:

- Ability to recruit and support teams that are multi-disciplinary and multi-cultural to accommodate the community diversity
- Ability to respond within 2-4 hours
- Training in Needs Adapted Treatment Model and able to work with individuals and families on an ongoing basis as needed.
- Staff capable of prescribing and administering in the field

4. Education, outreach & collaboration
   - Program has signed linkage agreements with Health Homes, ER and hospital services to develop protocols for diversion of patients from emergency room and inpatient services.
   - Ability to provide public education to key stakeholders to maximize buy-in of non-traditional services

Other components THAT WILL SUPPORT THOSE described above:

- EHR and HIE connectivity to allow alerts and secure messaging and to obtain current medical records for the patient
- Agreements within and between each component on clinical protocols & risk management
- Immediate access to a hospital with psychiatric services and crisis-oriented services or alternative
- Availability of clinical consultation by mental health clinicians, as a resource for primary care providers
- Agreements with Medicaid Managed Care organizations to provide coverage for the service array under this project
- Involvement of a quality committee for oversight and surveillance of compliance with protocols and quality of care that includes an Incident Review Committee and Consumer Advisory Board

d. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

PPS Response (Limited to 200 Words)
The major challenge is to gain support and cooperation from all involved in managing a psychiatric crisis, including law enforcement personnel, healthcare providers, and crisis intervention counselors. Each has its own culture and operating norms that will have to change from long established activities.

e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve overlapping service areas. If there are no other PPSs within the same service area, then no response is required.

PPS Response (Limited to 200 Words)
Since no adjacent PPS in the Forestland service area is undertaking project 3.a.ii, no coordination activities were developed for this project.

2. <u>Scale of Implementation</u> (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information:

a. Please indicate the total number sites the PPS intends to include in the project by the end of Demonstration Year (DY) 4, or sooner as applicable. This number should be entered in the table as *Total Committed*.

Project Scale	Number Committed
Expected Number of Crisis Intervention Programs Established	10

Please identify the number of committed providers who are a part of the local Safety Net.

Project Scale	Number of Committed That Are Safety Net Providers*	Number of Safety Net Providers*	Percent of Safety Net Providers (10 Points)
Primary Care Physicians	25	21	3
Non-PCP Practitioners	25	14	23
Hospitals	3	2	25
Clinics	2	3	19
Health Home/Care Management	10	2	20
Behavioral Health	10	7	23
Substance Abuse	5	3	30
Community Based Organizations	15	0	0
All Other	5	0	0

**Based on Department of Health Safety Net Provider designation*

b. Please indicate the total expected volume of patients the PPS intends to engage throughout this project by the end of Demonstration Year (DY) 4. This will become the *Expected # of Actively Engaged Patients*. Patient scale is measured by the total number of patients that are expected to be actively engaged by the end of Demonstration Year 4.

Patient Scale	Commitment
Targeted Population to Benefit from Project	253,500
Total Attributed Population	422,500
% of Total Attributed to Benefit from Project	100%

3. <u>Speed of Implementation/Patient Engagement</u> (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information:

a. Please indicate the Demonstration Year (DY) and Quarter by which all participating sites will achieve project requirements. **Project speed is measured by how fast all the project requirements for all chosen locations are met.**

PPSs will be expected to meet these requirements for all of the providers, sites, or other categories of entities included in the PPS "total committed" scale metric, unless otherwise specified in the Domain 1 DSRIP Project Requirements Milestones and Metrics.

Project Implementation Speed	DY0 (Baseline)		DY1		DY2		DY3		DY 4	
	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4
All Project Requirements Achieved										X

b. Please indicate the expected timeline for achieving 100% engagement of total expected number of actively engaged patients identified. For example, the PPS may indicate that 25% of patients will be actively engaged by the end of Demonstration Year (DY) 1, 50% by the end of DY2, and 100% by the end of DY 3.

Patient Engagement Speed	DY0 (Baseline)		DY1		DY2		DY3		DY 4	
	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4
Number of Actively Engaged Patients	50700	50700	101400	101400	152100	152100	202800	202800	253500	253500
Expected # of Actively Engaged Patients	253500	253500	253500	253500	253500	253500	253500	253500	253500	253500
% of Patients that are Actively Engaged	20	20	40	40	60	60	80	80	100	100

**For this project, Actively Engaged is defined as participating patients receiving crisis stabilization services from participating sites, as determined in the project requirements*
Please note: It is expected that the baseline number of patients engaged in this project may be 0. If so, please indicate 0 in the Year 0 baseline column.

4. Project Resource Needs and Other Initiatives (750 word limit, Not Scored)

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
X	

If yes: Please describe why capital funding is necessary for the Project to be successful.

PPS Response (Limited to 375 Words)
Capital budget funding is required for mobile team vehicles and equipment and some renovation to create an effective and efficient psychiatric emergency facility. Other expenditures may be required to upgrade IT EHR systems to facilitate care coordination. Capital requirement estimates will be developed in conjunction with the FPPS facilities and IT staff.

b. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
	X

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Name of Entity	Medicaid/Other Initiative	Project Dates	Description of Initiatives

c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

PPS Response (Limited to 375 Words)

5. **Domain 1 DSRIP Project Requirements Milestones & Metrics:**
   Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

   PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards completion of project requirements, scale of project implementation, and patient engagement progress in the project.

   a. **Detailed Implementation Plan:** By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

Quarterly Reports: PPS will submit quarterly reports on progress towards achievement of project requirements as defined in Domain 1 DSRIP Project Requirements Milestones & Metrics. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.

3.b.i Evidence-Based Strategies for Disease Management in High Risk/Affected Populations (Adults Only)

Project Objective: To support implementation of evidence-based best practices for disease management in medical practice for adults with cardiovascular conditions. (Adults Only).

Project Description: The goal of this project is to ensure clinical practices in the community and ambulatory care setting use evidence based strategies to improve management of cardiovascular disease. These strategies are focused on improving practitioner population management, adherence to evidence-based clinical treatment guidelines, and the adoption of activities that will increase patient self-efficacy and confidence in self-management. Strategies from the Million Hearts Campaign (http://millionhearts.hhs.gov) are strongly recommended.

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the attachment: **Domain 1 DSRIP Project Requirements Milestones & Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements.

1. Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.
2. Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.
3. Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year (DY) 3.
4. Use EHRs or other technical platforms to track all patients engaged in this project.
5. Use the EHR or other technical platform to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).
6. Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.
7. Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.
8. Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.
9. Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.
10. Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.

Improve Medication Adherence:

11. Prescribe once-daily regimens or fixed-dose combination pills when appropriate.

Actions to Optimize Patient Reminders and Supports:

12. Document patient driven self-management goals in the medical record and review with patients at each visit.
13. Follow up with referrals to community based programs to document participation and behavioral and health status changes
14. Develop and implement protocols for home blood pressure monitoring with follow up support.
15. Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.
16. Facilitate referrals to NYS Smoker's Quitline.
17. Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.
18. Adopt strategies from the Million Lives Campaign.
19. Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.
20. Engage a majority (at least 80%) of primary care providers in this project.

Partners Participating in this Project

Please list the name of the providers for this selected project along with identification numbers.

Provider Name	NPI
Forestland Hospital Center	1467645681

Project Response & Evaluation (Total Possible Points – 100):

1. **<u>Project Justification, Assets, Challenges, and Needed Resources</u> (1000 word limit, Total Possible Points – 20)**

   a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design and sites included. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

PPS Response (Limited to 400 Words)
Our Forestland CNA revealed that the highest incidence of potentially preventable admissions for cardiovascular conditions is in North/Central Forestland and Juniper Hill-Ash Park, Birchview and North Birchview. These areas also account for the highest percentage of potentially preventable emergency room visits, of which 65% to 80% could be prevented. In those geographic areas there is a tremendous opportunity for achieving significant financial savings by utilizing non-acute care settings to safely diagnose and manage more cost effectively Medicaid patients with possible cardiovascular conditions. Many patients presenting cardiac-like symptoms could be safely diagnosed and managed in appropriately staffed and equipped Patient Centered Medical Homes (PCMHs) distributed throughout the service area, where there currently is between 65 and 80% preventable ER and hospital usage (PPV

and PQI). These PCMHs would have qualified primary care physicians (with cardiologists on call or available tele-medically) to determine if patients needed to be seen in the ER.
These same PCMHs could also be adapted to provide on-going management, monitoring and education of patients at high risk for cardiovascular conditions. Having these resources in the patients' communities will allow for easier coordination with their primary care physicians. At these centers, patients could receive cardiovascular risk factor mitigation including nutritional counseling, exercise therapy, smoking cessation and other preventive care and wellness services at these centers, employing the best evidence based cardiovascular prevention/wellness and disease management practices found in the "Million Hearts Campaign". An additional benefit of placing these centers throughout the community is that the PCMH physicians there will be able to train community physicians in best evidence based cardiovascular disease management and risk prevention/wellness practices, many of which would also aid patients with diabetes.

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population be specific and could be based on geography, disease type, demographics, social need or other criteria. This patient population that the PPS expects to actively engage over the course of the project will be a subset of the total attributed population..

PPS Response (Limited to 200 Words)

There are two sub-groups in the target population.

- Medicaid patients with cardiac-like symptoms who traditionally present to the Juniper Hill ED
- Patients identified in the PCMHs as having the highest cardiac risk factors

c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

PPS Response (Limited to 400 Words)

The first of the existing resources to be mobilized are physicians currently taking care of Medicaid patients in Juniper Hill. Primary care physicians with the best PQIs and PPVs for their Medicaid patients with cardiovascular conditions (especially those who also have diabetes) will be recruited for the specialized PCMHs. Also, there will be care managers and coordinators, nutritionists, exercise therapists, and healthy lifestyle/wellness counselors deployed to the PCMHs to provide both preventive and cardiovascular disease management services.

d. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

PPS Response (Limited to 200 Words)
The biggest challenge will be changing behavior of both Medicaid patients and their primary care physicians. Medicaid patients are accustomed to seeking all care through the Emergency Room. The change will be to seek care for their cardiac-mimicking symptoms at the re-purposed PCMHs. The physicians there will not be their primary care physicians (or clinicians that they may have become accustomed to seeing in ERs). So, these clinicians in these re-purposed PCMHs will not initially be so familiar with these patients. However, because of their special expertise in understanding and ruling in or out serious cardiac problems, they will ultimately be in a position to better serve the needs of these patients. The challenges will be addressed through a combination of convenience (closer to home, walk-in access and short wait times) and outreach through a multi-lingual multi-media marketing campaign.

e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve overlapping service areas. If there are no other PPSs within the same service area, then no response is required.

PPS Response (Limited to 200 Words)
While there are 3 other PPSs within Forestland Health's service area, each serves a distinct population, with considerably segregated patient access patterns. Coordination between other PPSs will consist of sharing experiences and leading practices, but will not include any shared patients or resources.

2. <u>Scale of Implementation</u> (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information:

a. Please indicate the total number of sites, programs and/or providers the PPS intends to include in the project by the end of Demonstration Year (DY), or sooner as applicable. These numbers should be entered in the table as *Total Committed*.

Project Scale	Total Committed (10 Points)	Number in Network
Primary Care Physicians	650	2000
Non-PCP Practitioners	300	200
Clinics	20	60
Health Home/Care Management	2	10
Behavioral Health	20	40
Substance Abuse	20	10
Pharmacy	20	1000
Community Based Organizations	20	150
All Other	20	150

Please identify the number of committed providers who are a part of the local Safety Net.

Project Scale	Number of Committed That Are Safety Net Providers*	Number of Safety Net Providers*	Percent of Safety Net Providers (10 Points)
Primary Care Physicians	425	700	61
Non-PCP Practitioners	20	60	33
Clinics	15	42	36
Health Home/Care Management	2	2	100
Behavioral Health	15	30	50
Substance Abuse	15	10	150
Pharmacy	15	20	75
Community Based Organizations	15	0	0
All Other	15	0	0

**Based on Department of Health Safety Net Provider designation*

Please note: The threshold for the implementation of disease management evidence-based best practices requires 80% PCP engagement.

b. Please indicate the total expected volume of patients the PPS intends to engage throughout this project by the end of Demonstration Year (DY) 4. This will become the *Expected # of Actively Engaged Patients*. Patient scale is measured by the total number of patients that are expected to be actively engaged by the end of Demonstration Year 4.

Patient Scale	Commitment
Targeted Population to Benefit from Project	235,500
Total Attributed Population	422,500
% of Total Attributed to Benefit from Project	60%

3. <u>Speed of Implementation/Patient Engagement</u> (Total Possible Points - 40):
DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active

engagement of patients will receive more funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information:

a. Please indicate the Demonstration Year (DY) and Quarter by which all participating PCPs will achieve project requirements. **Project speed is measured by how fast all the project requirements for all chosen locations are met.**

PPSs will be expected to meet these requirements for all of the providers, sites, or other categories of entities included in the PPS "total committed" scale metric, unless otherwise specified in the Domain 1 DSRIP Project Requirements Milestones and Metrics.

Project Implementation Speed	DY0 (Baseline)		DY1		DY2		DY3		DY 4	
	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4
All Project Requirements Achieved										✔

b. Please indicate the expected timeline for achieving 100% engagement of total expected number of actively engaged patients identified. For example, the PPS may indicate that 25% of patients will be actively engaged by the end of Demonstration Year (DY) 1, 50% by the end of DY2, and 100% by the end of DY 3.

Patient Engagement Speed	DY0 (Baseline)		DY1		DY2		DY3		DY 4	
	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4
Number of Actively Engaged Patients	0	0	63375	63375	12675	12675	190125	190125	235500	235500
Expected # of Actively Engaged Patients	235500	235500	235500	235500	235500	235500	235500	235500	235500	235500
% of Patients that are Actively Engaged	0%	0%	25%	25%	50%	50%	75%	75%	100%	100%

**For this project, Actively Engaged is defined as the number of participating patients receiving services from participating providers with documented self-management goals in medical record (diet, exercise, medication management, nutrition, etc.).*

Please note: It is expected that the baseline number of patients engaged in this project may be 0. If so, please indicate 0 in the Year 0 baseline column.

4. Project Resource Needs and Other Initiatives (750 word limit, Not Scored)

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
X	

If yes: Please describe why capital funding is necessary for the Project to be successful.

PPS Response (Limited to 375 Words)
This project will require capital budget funding. Current ambulatory clinics serving the targeted PCMHs will be renovated to serve as cardiovascular disease prevention, evaluation and treatment centers. The new centers serving the targeted PCMHs will need to have areas re-outfitted to support primary care physicians with special expertise in avoiding hospitalizations and ER visits for Medicaid patients presenting with potential cardiac problems, consulting cardiologists (either in person or tele-medically) and other clinicians such as advanced practice nurses and physicians' assistants nutritionists and counselors. They will need to have more EKGs, cardiac ultrasounds, and access to labs that can do cardiac enzyme level determinations quickly. For the portions of the centers dedicated to cardiovascular wellness, there will need to be areas for nutritional counseling and tobacco cessation sessions.

b. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
X	

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Name of Entity	Medicaid/Other Initiative	Project Dates	Description of Initiatives

c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

PPS Response (Limited to 375 Words)
Approximately one quarter of providers in these areas are involved with at least one similar, but not identical, Medicaid initiative to improve cardiovascular health. These have to do with initiatives by Medicaid Managed Care Plans focused on trying to decrease the number of patients with indigestion and other causes of chest pain over-utilizing the ER. The current project will not only build upon these efforts, but also take advantage of their learnings and the experience of those providers taking part of them to become leaders of the current project. The current project will build upon the learnings from the Medicaid Health Plan initiative noted above by expanding PCMH services to Medicaid patients in a broad array of cardiovascular prevention, evaluation, fitness/wellness and nutritional counseling benefits.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards scale of project implementation, completion of project requirements and patient engagement progress in the project.

a. Detailed Implementation Plan: By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

b. Quarterly Reports: PPS will submit quarterly reports on progress towards achievement of project requirements as defined in Domain 1 DSRIP Project Requirements Milestones & Metrics. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.

3.c.i Evidence based strategies for disease management in high risk/affected populations. (Adult only)

Project Objective: Support implementation of evidence-based best practices for disease management in medical practice related to diabetes.

Project Description: The goal of this project is to ensure clinical practices in the community and ambulatory care setting use evidence based strategies to improve management of diabetes. Specifically, this includes improving practitioner population management, increasing patient self-efficacy and confidence in self-management, and implementing diabetes management evidence based guidelines.

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the attachment: **Domain 1 DSRIP Project Requirements Milestones and Metrics,** which will be used to evaluate whether the PPS has successfully achieved the project requirements.

1. Implement evidence based best practices for disease management, specific to diabetes, in community and ambulatory care settings.
2. Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.
3. Develop care coordination teams (including diabetes educators, nursing staff, behavioral health providers, pharmacy, community health workers, and Health Home care managers) to improve health literacy, patient self-efficacy, and patient self-management.
4. Develop "hot spotting" strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.
5. Ensure coordination with the Medicaid Managed Care organizations serving the target population.
6. Use EHRs or other technical platforms to track all patients engaged in this project.
7. Meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year (DY) 3 for EHR systems used by participating safety net providers.

Partners Participating in this Project
Please list the name of the providers for this selected project along with identification numbers.

Provider Name	NPI
Forestland Hospital Center	1467645681

Project Response & Evaluation (Total Possible Points – 100):

1. **<u>Project Justification, Assets, Challenges, and Needed Resources</u> (1000 word limit, Total Possible Points – 20)**

   a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the

findings from the Community Needs Assessment with the project design and sites included. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

PPS Response (Limited to 400 Words)
Diabetes is the most significant health problem in Forestland. The number of beneficiaries in Forestland Health PPS with diabetes-related utilization in 2012 was almost 46,475, 11% of the total beneficiary population of 422,500. Although the rate of short-term diabetes-related admissions in Forestland is below the NYS average, there is variation between neighborhoods. For example, the rate in Hazelcrest it is 213 per 100,000 people, nearly twice the NYS average. And the hospitalization rate for uncontrolled diabetes is highest in Hazelcrest and Birchview. The principal drivers of diabetes-related utilization are believed to be poor access to primary care, insufficient patient education, and insufficient monitoring. This project proposes to address the needs of diabetics in Forestland by incorporating specialized diabetes prevention education and treatment capabilities into 40 our currently underdeveloped Patient-Centered Medical Homes (PCMHs). The type of services provided will include counseling and treatment of patients with new, brittle, and/or uncontrolled diabetes. In addition, part of the service offerings will involve intensive re-education of Medicaid patients' primary care physicians to adhere to best evidence based practices in coordinating and transitioning the care of these patients including patient/family education and self-management. Because many, if not most, of these patients with diabetes most suitable for these services also have cardiovascular disease, we will integrate the specialized cardiovascular diagnostic and treatment capabilities also incorporated into the PCMHs (see our response for project 3bi) into the same PCMHs to be most cost effective. We seek to establish two pilot projects for incorporating this intensive approach to diabetes prevention, evaluation and treatment-- one in Birchview and one in Hazelcrest during DSRIP Years 1 and 2. The initial effort will be to re-purpose the existing ambulatory care clinics of the PCMHs to take on these specialized services. This will be followed by recruiting physicians, advanced practice nurses, physicians' assistants, care, case, disease management and social workers, nutritionists and pharmacists with specialized expertise in diabetes. We will collect data for the attributable Medicaid population for Birchview and Hazelcrest to establish a baseline of diabetes disease load and PQI and PPV (preventable hospitalization and ER admissions) to identify the target patient cohort. The second year will be dedicated to channeling diabetes patients to the enhanced PCMHs, instituting care coordination and patient education programs, performing community outreach, establishing evidence based care pathways that continue into the patients' homes, and ensuring data exchange capabilities with existing primary care providers in the pilot communities. During this time, we will also capture the learnings from this pilot to replicate it first in other areas of highest PQI and PPV for uncontrolled diabetes, and then to the rest of GFL by the end of DSRIP Year 4

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population be specific and could be based on geography, disease type, demographics, social need or other criteria. This patient population that the PPS expects to actively engage over the course of the project will be a subset of the total attributed population.

PPS Response (Limited to 200 Words)
The target population for this project will be Medicaid patients residing in Hazelcrest and Birchview with diabetes. The CNA and focus groups confirmed the overwhelming importance of obesity and the inaccessibility and affordability of nutritious foods in Hazelcrest and Birchview (among other areas of GFL). Improving this access and affordability of healthy foods (see subsection 1d, below) could go a long way toward decrease avoidable hospital and ER use for the complications of diabetes (see pp. 51-2 of the CNA). Upon demonstrating the success of the pilot in Hazelcrest and Bircheview, we will rapidly replicate it throughout FL (sequentially to those communities where there is the greatest improvement potential in adherence to best practices and enhancement of population health).

c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

PPS Response (Limited to 400 Words)
Existing Forestland Hospital Center (FHC) specialty staff, such as endocrinologists, will be recruited for tele-medical sessions for patients in these repurposed PCMHs. Until new staff can be hired, existing FHC nutritionists, exercise and fitness trainers, diabetes disease and case/care managers, social workers and certified health educators will be deployed. Public health agencies and schools will also be mobilized to serve as venues for educational programs.

d. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

PPS Response (Limited to 200 Words)
Establishing a healthy diet and starting and maintaining an exercise regimen are notoriously difficult lifestyle changes for patients in any socioeconomic stratum. Modifying these ingrained behaviors is especially difficult in the Medicaid population. Access to healthy eating alternatives is a challenge. In addition, there are relatively few health clubs or other facilities available. In addition, those physicians and other clinicians who have the best PQI records may be too committed to their own patients to be available to serve as even virtual (or tele-medical) advisors to the PCMHs. Care, disease, and case managers and social workers have many other commitments. So, it might be difficult to recruit and repurpose them to focus primarily on patients with diabetes. To overcome the challenges, there will need to be incentives (financial and/or professional) put into place. Neighborhoods will need to provide incentives for restaurants and groceries to carry healthier fare. Heath clubs will need special accommodations to be motivated to expand into the demographic areas where they can have the greatest positive impact on patients. We are discussions with NY City officials to develop a package of incentives for retailers.

There will need to be special career tracks for care, case and disease managers to focus on patients with the highest rates of preventable hospitalizations for the complications of uncontrolled diabetes. Transportation services will be developed for patients for home and work that they might need to leave would need to be picked up to minimize preventable hospitalizations of their patients with other conditions.

e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve overlapping service areas. If there are no other PPSs within the same service area, then no response is required.

PPS Response (Limited to 200 Words)
Forestland Health is the largest PPS in Forestland, and therefore is attributed the greatest portion of Medicaid beneficiaries living with diabetes. Since patient access patterns across each of the Forestland PPSs are distinct, there will be no overlap in diabetes care plans. Coordination across PPSs will consist of sharing experiences and best practices, but there will be no patient or clinical coordination.

2. <u>Scale of Implementation</u> (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information:

a. Please indicate the total number of sites, programs and/or providers the PPS intends to include in the project by the end of Demonstration Year (DY), or sooner as applicable. These numbers should be entered in the table as *Total Committed*.

Project Scale	Total Committed (10 Points)	Number in Network
Primary Care Physicians	650	2000
Non-PCP Practitioners	400	200
Clinics	20	60
Health Home/Care Management	2	10
Behavioral Health	15	40
Substance Abuse	15	10
Pharmacy	15	1000
Community Based Organizations	15	150
All Other	15	120

Please identify the number of committed providers who are a part of the local Safety Net.

Project Scale	Number of Committed That Are Safety Net Providers*	Number of Safety Net Providers*	Percent of Safety Net Providers (10 Points)
Primary Care Physicians	425	700	61
Non-PCP Practitioners	200	60	333
Clinics	10	42	24
Health Home/Care Management	2	2	20
Behavioral Health	8	30	27
Substance Abuse	8	10	80
Pharmacy	8	20	40
Community Based Organizations	8	0	0
All Other	8	0	0

**Based on Department of Health Safety Net Provider designation*

Please note: The threshold for the implementation of disease management evidence-based best practices requires 80% PCP engagement.

b. Please indicate the total expected volume of patients the PPS intends to engage throughout this project by the end of Demonstration Year (DY) 4. This will become the *Expected # of Actively Engaged Patients*. Patient scale is measured by the total number of patients that are expected to be actively engaged by the end of Demonstration Year 4.

Patient Scale	Commitment
Targeted Population to Benefit from Project	169,000
Total Attributed Population	422,500
% of Total Attributed to Benefit from Project	40%

3. Speed of Implementation/Patient Engagement **(Total Possible Points - 40):**

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information:

a. Please indicate the Demonstration Year (DY) and Quarter by which all participating primary care providers will achieve project requirements. **Project speed is measured by how fast all the project requirements for all chosen locations are met.**

PPSs will be expected to meet these requirements for all of the providers, sites, or other categories of entities included in the PPS "total committed" scale metric, unless otherwise specified in the Domain 1 DSRIP Project Requirements Milestones and Metrics.

Project Implementation Speed	DY0 (Baseline)		DY1		DY2		DY3		DY 4	
	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4
All Project Requirements Achieved						✔				

b. Please indicate the expected timeline for achieving 100% engagement of total expected number of actively engaged patients identified. For example, the PPS may indicate that 25% of patients will be actively engaged by the end of Demonstration Year (DY) 1, 50% by the end of DY2, and 100% by the end of DY 3.

Patient Engagement Speed	DY0 (Baseline)		DY1		DY2		DY3		DY 4	
	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4
Number of Actively Engaged Patients	0	42250	42250	84500	84500	126,75	126,75	169000	169000	169000
Expected # of Actively Engaged Patients	169000	169000	169000	169000	169000	169000	169000	169000	169000	169000
% of Patients that are Actively Engaged	0%	25%	25%	50%	50%	75%	75%	100%	100%	100%

For this project, Actively Engaged is defined as the number of participating patients with at least one hemoglobin A1c test within previous Demonstration Year (DY).
Please note: It is expected that the baseline number of patients engaged in this project may be 0. If so, please indicate 0 in the Year 0 baseline column.

4. <u>Project Resource Needs and Other Initiatives</u> (750 word limit, Not Scored)

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
X	

If yes: Please describe why capital funding is necessary for the Project to be successful.

PPS Response (Limited to 375 Words)
This project will require capital budget funding to renovate the ambulatory clinics used by the PCMHs in Birchview and Hazelcrest to focus on specialized diabetes prevention, evaluation and treatment. There will need to be accommodations for specialized case and care managers, nutritionists, healthy lifestyle/wellness and exercise counselors. In addition, it may be useful to rent space in community centers or other locations to serve as patient education venues.

b. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
X	

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Name of Entity	Medicaid/Other Initiative	Project Dates	Description of Initiatives

c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

PPS Response (Limited to 375 Words)
Because diabetes is so prevalent in GFL, approximately half of the providers involved in this project plan have been (or currently are) involved in other agency initiatives similar to (but not identical to) this project. Diabetes is a classic condition requiring close care coordination especially in the outpatient setting to avoid out of control blood sugars and the various organ system failures and complications necessitating acute care. Consequently, it has been a key condition of focus for Managed Medicaid plans.

Managed Medicaid plans that have focused on diabetes involve at least half of the PCPs and their extended care provider team members participating in the pilots in Birchview and Hazelcrest, as well as throughout GFL. We will leverage their experience and expertise in our proposed project to improve the adherence of both PCPs and their Medicaid patients in best evidence based care and self-management practices respectively. Doing so should decrease the incidence of uncontrolled diabetes and its complications necessitating otherwise avoidable hospital and ER use.

This project (once the pilot can be demonstrated to be successful and expanded throughout GFL) goes beyond that of similar Managed Medicaid programs focusing on decreasing avoidable hospital and ER use by patients with diabetes. For one thing, it will be provider-driven and not health plan-driven. It will also bring in a considerably wider group of providers (specialized care, case and disease managers with specialized expertise and experience in treating patients with diabetes and keeping them out of the ER and hospital settings).
Plus there will be nutritionists and even exercise counselors for those patients with pre-diabetes or even early stage Type II diabetes for whom changing diet and following a gradually more intensive exercise regimen may forestall or even reverse the diabetes disease process. We will build upon the Medicaid Managed care initiatives that have focused on the prevention, evaluation and treatment of patients with diabetes. We will especially leverage the Medicaid managed care plans expertise, technologies, resources and financial incentives (whenever possible) to bolster our own efforts in the PCMHs.

5. <u>Domain 1 DSRIP Project Requirements Milestones & Metrics:</u>

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards <u>completion of project requirements,</u> <u>scale of project implementation,</u> and <u>patient engagement progress</u> in the project.

a. Detailed Implementation Plan: By March 1, 2015 PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed

and scale submissions with the project application will directly impact Domain 1 payment milestones.

Quarterly Reports: PPS will submit quarterly reports on progress towards achievement of project requirements as defined in Domain 1 DSRIP Project Requirements Milestones & Metrics. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.

4.a.iii Strengthen Mental Health and Substance Abuse Infrastructure across Systems (Focus Area 3)

Project Objective: This project will help to strengthen mental health and substance abuse infrastructure across systems.

Project Description: Support collaboration among leaders, professionals, and community members working in MEB health promotion to address substance abuse and other MEB disorders. MEB health promotion and disorders prevention is a relatively new field, requiring a paradigm shift in approach and perspective. This project will address chronic disease prevention, treatment and recovery, and strengthen infrastructure for MEB health promotion and MEB disorder prevention. Meaningful data and information at the local level, training on quality improvement, evaluation and evidence-based approaches, and cross-disciplinary collaborations need to be strengthened.

Project Requirements: The PPS must show implementation of three of the four sector projects in their project plan. The implementation must address a specific need identified in the community assessment and address the full service area population. For each sector project, specific potential interventions are identified on the Preventive Agenda website under "Interventions to Promote Mental Health and Prevent Substance Abuse" (http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/mhsa/interventions.htm).

1. Participate in MEB health promotion and MEB disorder prevention partnerships.
2. Expand efforts with DOH and OMH to implement 'Collaborative Care' in primary care settings throughout NYS.
3. Provide cultural and linguistic training on MEB health promotion, prevention and treatment.
4. Share data and information on MEB health promotion and MEB disorder prevention and treatment.

Partnering with Entities Outside of the PPS for this Project
Please provide the name of any partners included for this project outside of the PPS providers. This may include an entity or organization with a proven track record in addressing the goals of this project.

Entity Name

Project Response & Evaluation (Total Possible Points – 100):

1. **<u>Project Justification, Assets, Challenges, and Needed Resources</u> (1500 word limit, Total Possible Points – 100)**

    a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

PPS Response (Limited to 500 Words)

As outlined in the DSRIP toolkit, MEB health promotion and disorders prevention is a relatively new field, requiring a paradigm shift in approach and perspective. The results of our Community Needs Assessment (CNA) analysis unequivocally demonstrate the widespread need to address behavioral health concerns and substance abuse conditions. Mental and behavioral health disorders due to accidental poisoning and other psychoactive drug abuse features as one of the 10 leading causes of death among the White, Hispanic and Black populations in Forestland. In addition, behavioral health issues are one of the three top conditions most reported to affect health of Forestland residents. Access to mental health services is reported to be limited, although community organizations and residents are not always aware of available services or how to access them. In addition, behavioral health issues generally carry greater stigma than other health concerns, which further limits use of services. Key informants and focus group participants both reported that many affected families try to address problems internally.

While overall service utilization rates in Forestland for behavior health and substance abuse are lower than the city and state averages, they range considerably throughout the county, with the highest rates of behavior health utilization clustered in North/Central Forestland and Juniper Hill-Ash Park, and the highest rates for substance abuse utilization clustered in Downtown, Hazelcrest, and Chestnut Heights. (See Appendix A. Map 33.)

The field of MEB covers a large range and variety of illnesses, which will require distinct approaches in order to yield effective results. Key behavioral health challenges reported through our focus groups included:

1. Very high smoking rates among the Chinese and Arab populations
2. Widespread problems of obesity due to poor dietary behaviors – this problem is ubiquitous throughout all Forestland neighborhoods
3. Alcohol and drug abuse, particularly among the homeless populations

While Forestland does have significant expertise in MEB, and a range of providers currently in the community, capacity and access remain an issue. Of particular note, there are 536 general psychiatrists in Forestland, which is a rate of 21.1 per 100,000, much lower than the GFL rate of 49 per 100,000. There are 4,899 social workers in Forestland, or 192.7 per 100,000 compared to 231 per 100,000 in GFL. There is a large gap which will need to be filled in order to provide prevention and educational services that are culturally sensitive and that address the problems of our ethnically diverse population. Both the Forestland Alliance on Mental Illness (FAMI) and the Forestland Welcoming Center provide important educational services, the former specifically on behavioral health issues and the latter specifically to immigrants to Forestland. The current infrastructure for behavioral health and substance abuse does not support an integrated, concerted approach to prevention, treatment and recovery. For this reason, we specifically chose to implement the integration of primary and behavioral health services as our Domain 3 project, which will enable our providers to target behavioral health issues directly as they present in primary care practices.

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population *must be specific and could be based on geography, disease type, demographics, social need or other criteria.*

PPS Response (Limited to 300 Words)
Our PPS will focus its outreach approach in the areas of North/Central Forestland, Juniper Hill-Ash Park, Downtown, Hazelcrest, Chestnut Heights, Sap Valley and Cedar Bay. As explained above, these areas are characterized by large populations of non-English speaking immigrants, undocumented persons and homeless. Key behavioral problems include smoking, alcohol and drug abuse and poor dietary behaviors. In total, we expect to target approximately 50,000 individuals in our directed outreach levels. This number is, in part, based on extrapolating current data on the use of formalized behavioral health services to account for the reported underuse of services due to problems of access and cultural influences. The composition of the Forestland population calls for approaches that are both racially and culturally sensitive. Approximately 17% of Forestland's population are not US citizens, but this figure likely underestimates the immigrant population in Forestland, because the number of undocumented individuals is reported to be substantial. Nearly half (46%) of Forestland residents report speaking a language other than English at home. Within the county, high proportions of non-citizens are found in Sap Valley and Cedar Bay. These areas, along with Plum Ridge and Juniper Hill, also have high rates of residents who speak English less than "very well".

c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

PPS Response (Limited to 500 Words)
From the initial selection of 4, we have decided to implement the following three sector projects based on the results of our community needs assessment: 1. Participate in MEB health promotion and MEB disorder prevention partnerships (project 2) Since we are collaborating with our neighboring PPSs, we will work together to establish a regional Prevention Partnership Committee. The committee will be in charge of selecting appropriate evidence-based approaches to implement for the prevention, treatment and recovery services for our identified problem areas and targeted population. Given the populations that we work with, the cultural and linguistic sensitivities are key (see project 3). Educating our populations is a cornerstone of our approach to enhancing the overall infrastructure. As a first order of business, the committee will also be responsible for overseeing the roll out of more streamlined forms of data collection that will enable us to track progress in an outcome-based manner (see project 4). 2. Provide cultural and linguistic training on MEB health promotion, prevention and treatment (project 3). Forestland, access to mental health services can be limited, due in part to the fact that, behavioral health issues generally carry greater stigma than other health concerns, which

tends to limit use of services. In many of the immigrant cultures in Forestland the tendency is to avoid treatment and "keep it in the family". Providing training to providers across the care continuum focused on culturally and linguistically appropriate MEB health promotion, treatment, and prevention is critical. It is our goal to develop targeted education materials for each of the identified areas of concern: smoking, alcohol and substance abuse and dietary behaviors. Materials will be developed for the purpose of outreach, as well as for patients that are already in-treatment. We will need to develop a methodology for assessing the impact of our efforts on the actual acceptance levels of behavioral health issues in the community as well as the utilization of appropriate services. We will partner with our neighboring PPSs and the Office of Mental Health and Hygiene to develop appropriate data collection and evaluation methods (Project 4).

3. Share data and information on MEB health promotion and MEB disorder prevention and treatment (project 4).
   In order to capture information on our population needs from both formalized healthcare providers and community-based organizations, we will make use both of EMR systems as well as a select set of data collection methods such as surveys and questionnaires to keep a full view of needs both in the utilizing and non-utilizing populations.

d. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

PPS Response (Limited to 300 Words)

Access to information
A challenge for our PPS in strengthening our collective infrastructure to address MEB and substance abuse disorders will be the collection of robust data on standardized metrics that will allow us to measure improvements to population health in an outcome-focused manner. To date, we have been unable to collect information on metrics such as DALYs and YPLL. We aim to set up new partnerships with our local office of mental health in order to measure and track population need. Given the overlap of our PPS's service area with that of two others in the county, we have been in constant conversation over the past couple of months in order to ensure that our collective approach to program organization and data collection are aligned and employ the same resources.

Social Factors
Poverty and other psychosocial stresses have a clear impact generally on MEB disorders. Low-income Forestland residents describe very stressful lives, with concerns that include, but are not limited to, employment, housing, safety, access to healthy food, and appropriate resources for children. These factors, along with the stigma related to many MEB disorders will continue to play a large role in the in emergence of MEB disorders and the success of prevention efforts. Utilizing culturally competent services and ensuring strong connection across the care continuum, including social supports will be critical to success.

e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve an overlapping service area. If there are no other PPS within the same service area, then no response is required.

PPS Response (Limited to 300 Words)

1. Participate in MEB health promotion and MEB disorder prevention partnerships (project 1). We will work this program together with our partners: the Forestland Department of Health and Mental Hygiene, Department of Youth and Community Development, the criminal justice offender services, the community centers, local CBOs, primary care practices and the behavioral health services in the outpatient and inpatient treatment centers in the Forestland hospitals.

2. Provide cultural and linguistic training on MEB health promotion, prevention and treatment (project 3). Our PPS will work together with the other PPSs in our geographic area, The Forestland Alliance on Mental Illness (FAMI) and the Forestland Welcoming Center to develop trainings for the general public and our target population in particular that is culturally sensitive and matches the observed literacy levels.

4. Share data and information on MEB health promotion and MEB disorder prevention and treatment (project 4).There is a dearth of local data on who is at risk for a MEB disorder and who would benefit from targeted promotion and interventions. We aim to partner with the Office of Mental Health and Hygiene to set up ways in which to measure and track population need according to standardized, outcome-related measures such as the DALY and YPLL measures.

f. Please identify and describe the important project milestones relative to the implementation of this project. In describing each of the project milestones relative to implementation, please also provide the anticipated timeline for achieving the milestone.

PPS Response (Limited to 100 Words)

[Our prototype response was drafted in response to the 29th September version of the application. This bullet point was added after that version, as a response to public comment. Our prototype does not, therefore, include a response to this bullet.]

2. Project Resource Needs and Other Initiatives (750 word limit, Not Scored)

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
	X

If yes: Please describe why capital funding is necessary for the Project to be successful.

PPS Response (Limited to 375 Words)

b. Are any of the providers within the PPS and included in the Project Plan PPS currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
	X

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Name of Entity	Medicaid/Other Initiative	Project Dates	Description of Initiatives

c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

PPS Response (Limited to 375 Words)

3. <u>Domain 1 DSRIP Project Requirements Milestones & Metrics:</u>

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due by March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards completion of project requirements.

a. Detailed Implementation Plan: By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.

b. Quarterly Reports: PPS will submit quarterly reports on progress towards achievement of project requirements as defined in the application. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.

4.b.ii Increase Access to High Quality Chronic Disease Preventative Care and Management in Both Clinical and Community Settings (Focus Area 3) (This project targets chronic diseases that are not included in Domain 3, such as cancer)

Project Objective: This project will help to increase access to high quality chronic disease preventative care and management in both clinical and community settings for chronic diseases that are not included in Domain 3 projects, such as cancer.

Project Description: The delivery of high-quality chronic disease preventive care and management can prevent much of the burden of chronic disease or avoid many related complications. Many of these services have been shown to be cost-effective or even cost-saving. However, many New Yorkers do not receive the recommended preventive care and management that include screening tests, counseling, immunizations or medications used to prevent disease, detect health problems early, and prevent disease progression and complications. This project is targeted on increasing the numbers of New Yorkers who receive evidence based preventative care and management for chronic diseases.

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the document, **Domain 1 DSRIP Project Requirements Milestones and Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements. The implementation must address a specific need identified in the community assessment and address the full service area population.

1. Establish or enhance reimbursement and incentive models to increase delivery of high-quality chronic disease prevention and management services.
2. Offer recommended clinical preventive services and connect patients to community-based preventive service resources.
3. Incorporate Prevention Agenda goals and objectives into hospital Community Service Plans, and coordinate implementation with local health departments and other community partners.
4. Adopt and use certified electronic health records, especially those with clinical decision supports and registry functionality. Send reminders to patients for preventive and follow-up care, and identify community resources available to patients to support disease self-management.
5. Adopt medical home or team-based care models.
6. Create linkages with and connect patients to community preventive resources.
7. Provide feedback to clinicians around clinical benchmarks and incentivize quality improvement efforts.
8. Reduce or eliminate out-of-pocket costs for clinical and community preventive services.

Partnering with Entities Outside of the PPS for this Project
Please provide the name of any partners included for this project outside of the PPS providers. This may include an entity or organization with a proven track record in addressing the goals of this project.

Entity Name
The Forestland Alliance on Mental Illness (FAMI)
The Forestland Catholic Progress of Peoples (FCPOP) Foundation
Forestland Financial Empowerment Center
Sap Valley Outreach Center
Forestland Seniors Association
Birchview Community Support Group
Forestland Welcoming Center

Project Response & Evaluation (Total Possible Points – 100):

1. **Project Justification, Assets, Challenges, and Needed Resources (1500 word limit, Total Possible Points – 100)**

   a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

PPS Response (Limited to 500 Words)
The majority (73.4%) of potentially preventable admissions in Forestland are for chronic conditions, particularly complications arising from the mismanagement of these conditions. This number has declined in recent years, but is still above the state average. It is clear from this that there is significant room to improve with regard to Forestland's prevention and management of chronic conditions, and that taking on project 4.b.ii can reduce avoidable hospital usage. 6% of Medicaid beneficiaries in Forestland currently suffer from respiratory conditions with much higher rates found in downtown clusters such as Sunflower Crescent, Juniper Hill, and Sap Valley. These respiratory conditions account for 25.3% of the potentially preventable hospitalizations caused by chronic conditions, and with the lack of services designed for these conditions described as 'huge.' The primary causes of these conditions have up to date been viewed as largely intractable issues such as poor housing conditions, pollution, (for asthma) and smoking (for COPD). Increasing the prevalence of smoking is an increased population of Chinese and Arab immigrants, wherein smoking is considered an indicator of maturity. Currently, a significant lack of competency and capacity in specialized community care to assist these distinct cultures is creating a barrier to care. An additional issue with the current state of chronic condition prevention and management in Forestland is the typical wait times involved for screening tests. Long wait times discourage the use of screening tests for various chronic conditions. Due to the segregation and lack of linkages between community and clinical services in regard to chronic condition prevention and management, individuals need to visit multiple clinics and services to undergo preventive care, deterring their use. Connected to the issue of the current low utilization of preventative care is primary care provider coverage. Many Medicaid beneficiaries in Forestland currently do not have or do not use their primary care providers – this leads to a lack of management. The key factor in this issue is accessibility: primary

care providers are located far away from the beneficiaries that need them, and their operating hours do not fit within the beneficiaries' schedules.
Another barrier to preventative care in the current state is the cost involved in care. Both in terms of time and money, populations at risk for chronic conditions fail to see prevention and management services as worthwhile. Deterring the use of preventative care through patient out-of-pocket costs is leading to greater costs for the health system when patients are inevitably hospitalized.
The last gap in care in the current state is the link between clinical and community care. Current community care coordinators, in addition to lacking the capacity to engage all at-risk populations, are rebuffed from getting information about their patients. There is no incentive for clinical care providers to communicate a patient's health or medication needs to the care coordinator. This disconnect is a prime factor in Forestland's current failure in avoiding preventable chronic condition-related hospital readmissions.

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population *must be specific and could be based on geography, disease type, demographics, social need or other criteria.*

PPS Response (Limited to 300 Words)

Current data suggests that 54.8% of Forestland's Medicaid population currently lives with a chronic medical condition. Project 4.b.ii targets Medicaid beneficiaries with any chronic condition excluding cardiovascular disease or diabetes (which have their own specialized projects), meaning 35.3% of the chronic disease population. These chronic conditions are primarily certain types of cancer, asthma, and COPD. In the Forestland PPS, this represents 115,799 people.
Geographically, the target patient population is spread out across Forestland, but with clusters of groups found in low-income neighborhoods with less access to preventative care. The main clusters are located in Maple Hill through Sap Valley, Hazelcrest, and East Forestland.
All ethnicities will be involved in this project, with special attention paid to making preventative more accessible for immigrant groups with linguistic barriers to care. Additionally, cultures wherein smoking is especially prevalent will be targeted for additional support, due to its causal link to cancer and COPD.

c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

PPS Response (Limited to 500 Words)

The main new resource that will need to be developed for the PPS's strategy for project 4.b.ii is the bulk order of Wi-Fi enabled tablets. This substantial set of tablets will be distributed to community care workers to coordinate preventative care and management for their patient sets, and to communicate to centrally located clinicians and specialists from within the communities. Additionally, tablets will be

distributed to high-risk patients provide rapid access to communication, as well as automated medication reminders.
The main current resource that will be expanded upon is the current base of care coordinators in Forestland. Community care workers will be recruited and drawn from the communities they live and work in, in order to improve both cultural competency and accessibility in chronic disease preventative care and management. The community care workers will be a part of the communities that their patient sets reside in, and will live nearby as well.
To determine where community care workers should be recruited from, a zip-code run of individual patients will indicate the high-density clusters of certain kinds of chronic conditions, allowing the formation of a disease registry. Community care workers can then be recruited from these locations to ensure the health system has a face in every community in need. In order to intelligently make use of current resources, significant efforts will be put into hiring community care workers from existing staff that need to be repurposed once hospital capacity is reduced as part of DSRIP.
To facilitate preventative care and management, community care workers will be equipped with Wi-Fi enabled tablet devices to assist them in providing accessible services to their patient. These tablets will allow the workers to quickly and remotely communicate with primary care providers and clinicians who have worked with the patients. Additionally, high-risk patients will themselves be provided tablets, which will send automatic reminders to take medication, to show up for upcoming appointments, and to communicate with their assigned community care workers.
This resource will be given a much larger role as preventative care and management is reformed, and its numbers and capabilities will grow significantly. Over time, these care workers will become quasi-experts in handling the chronic conditions of their communities and assigned patient sets, but will need intensive training and development to get there.
This shift from reactivity to proactivity in chronic disease preventative care and management will be achieved by the development, training, and expansion of Forestland's care coordinators, moving them from an ancillary service for select groups to the primary point of contact between individuals preventing or managing chronic conditions and the Forestland Health PPS. The work of community care workers is to meet the targeted populations in their communities and in their homes to provide education, testing/screening, and care coordination.
The main current resources that will need to be repurposed is the fleet of mobile diagnostic units. These units will dually serve as a mode of transportation for some community care workers, as well as a vital instrument in providing screening tests to populations in fringe communities with poor access to primary care.

d. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

PPS Response (Limited to 300 Words)
Another key piece of the strategy for project 4.b.ii is to introduce team-based care into chronic condition preventative care and management. Instead of trying and failing to get into contact with segregated health providers about medications and reports for each of their patients, community care

workers should be considered a vital part of the 'team' working with each patient. In the strategy, providers will be financially incentivized to communicate with community care workers, learn about where each patient stands, and inform the team on what treatment the patient has been receiving. Additionally, this team-based care format will allow community care workers to raise 'red flags' on patients that need to escalate the care they are receiving.
The main risks in this strategy are getting to the patients and overcoming trust and language issues. To overcome accessibility issues in getting preventative care to the patients, the community care workers will use mobile devices such as tablets and mobile diagnostic units in order to be able to provide care to patients from within their homes.
Also, since transportation and accessibility were seen as great barriers to care for beneficiaries living with chronic conditions, transportation to clinical services devised by community care workers will never be charged to the patients, which will lower the barriers to care and increase utilization.
Many Medicaid beneficiaries have trust issues with the health system, thinking that it does not have their best interests in mind, which prevents them from accessing vital preventative care and chronic condition management. This risk is mitigated by drawing community care workers from the actual communities that these patients reside in. By speaking the same language, trust issues should be able to be broken down, increasing the utilization of high quality preventative care practices.

e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve an overlapping service area. If there are no other PPS within the same service area, then no response is required.

PPS Response (Limited to 300 Words)
While there are 3 other PPSs within Forestland Health's service area, each serves a distinct population, with considerably segregated patient access patterns. Coordination between other PPSs will consist of sharing experiences and leading practices, but will not include any shared patients or resources.

f. Please identify and describe the important project milestones relative to the implementation of this project. In describing each of the project milestones relative to implementation, please also provide the anticipated timeline for achieving the milestone.

PPS Response (Limited to 300 Words)
[Our prototype response was drafted in response to the 29th September version of the application. This bullet point was added after that version, as a response to public comment. Our prototype does not, therefore, include a response to this bullet.]

2. <u>Project Resource Needs and Other Initiatives</u> (750 word limit, Not Scored)

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
X	

If yes: Please describe why capital funding is necessary for the Project to be successful.

PPS Response (Limited to 375 Words)
Capital budget funding will be necessary to acquire a sufficiently large set of tablets to equip community care workers and high risk patients with mobile devices. These will be used to improve care coordination, communication, and accessibility, as outlined in the strategy above.

b. Are any of the providers within the PPS and included in the Project Plan PPS currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
X	

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Name of Entity	Medicaid/Other Initiative	Project Dates	Description of Initiatives
Rosewood Medical Center	Asthma Outreach 2015	January 1st 2015 – December 31st 2015	For three days each week, a team of specialists from Rosewood Medical Center set up a tent by popular grocery stores in Forestland to deliver asthma testing

c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

PPS Response (Limited to 375 Words)
This existing project, taken on by one of the PPS's provider hospitals, is similar to the PPS's own project but much more limited in scope. The PPS's own project 4.b.ii brings community care to the homes of the individuals who need it, and addresses other conditions beyond asthma.

3. Domain 1 DSRIP Project Requirements Milestones & Metrics:

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due by March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards completion of project requirements.

a. Detailed Implementation Plan: By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.

Quarterly Reports: PPS will submit quarterly reports on progress towards achievement of project requirements as defined in the application. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.

Section 5 – PPS Workforce Strategy

(20% of the Overall PPS Structure Score)

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.

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.

Detailed workforce strategy identifying all workplace implications to the PPS

In this section, please describe the anticipated impacts on the workforce the DSRIP program will have and the overall strategy to minimizing the negative impact to the workforce. In the response, please include:

- Summarize how the existing workers will be impacted in terms of possible staff requiring redeployment, retraining, as well as potential reductions to workforce.

PPS Response (Limited to 600 Words)

Implementation of DSRIP projects will have dramatic and wide-ranging impact on many of the 20,000 employees in our PPS. Along with business-as-usual changes in staffing, new departments, organizations, and roles will be created across our partners to develop an integrated service delivery system. We anticipate there will be 1,000 new opportunities for employees in our combined group of 180 Forestland PPS partners as well as the PPS organizations that share 5 of our partners. In addition, Forestland is in the process of repositioning one of our 3 hospitals to make it financially viable and positioned to take on the role of a community hospital.

Together with the DSRIP Steering Committee, we created a comprehensive workforce strategy: the Forestland Health Workforce Strategy (FHWS) to ensure we have the right people, with the right skills, in the right place, at the right time, and the right cost. With our partners we created a workforce future-state template/model "Forestland Health Future" balances specific supply and demand for staff and underpins the FHWS. We are using two tactics to deliver this model:

1) Rapid workforce adjustment (RWA) will be used to fill vacancies identified in the workforce model. The objective of RWA is to rapidly create improved access to more healthcare resources in the community and selected inpatient settings. We cannot redirect patients away from inpatient services to seek care in settings where resources are absence 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 our population. RWA relies upon recruiting appropriately trained professionals and rapidly redeploying or retraining the workforce from overstaffed areas and organizations.

2) Incremental workforce adjustment (IWA) relies on retraining, redeploying, recruiting, staff reductions, and combinations of these tactics over time. IWA is largely dependent upon the reduced demand for staff that will result from the reduced inpatient volumes.

- Demonstrate the PPS' understanding on 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 greatest specifically citing the reasons for the anticipated impact.

PPS Response (Limited to 250 Words)

The following positions will be impacted:

- MD, DO, and Primary care physicians - N
- Dentists/Dental technicians - N
- Healthcare navigators – RD, RT, N
- Population Management experts - N
- Human Resources Professionals – RT, N
- Case managers – RD, RT, N
- Social Workers – RD, RT, N
- Home health workers – RT, N
- Allied Health professionals – RD, RT, N
- Nutritionists – RD, RT, N
- Healthcare Counselors – RT, N
- Registration clerks – RT, N
- Financial counseling staff – RT, N
- Paramedics and Emergency technicians – RT, N
- Translators/foreign language speakers - N
- RN/NA – RD, RT, N
- Physician Assistants, Nurse Practitioners and Family Nurse – RD, RT, N
- Communications and media experts - N
- Marketing professionals - N
- Managers/Supervisors – RD, RT, N
- Ambulatory Care practice managers – RD, N
- Mental health specialists, psychologists, MD psychiatrists - N
- Process redesign experts – RD, N
- Ancillary workers – RD, N
- Union/Non-Union – RD, RT, N

- Data analysts and statisticians – RD, N

The FHWS identified four drivers of change: 1) workload productivity management 2) the 11 DSRIP projects, 3) process improvement projects, and 4) turnover. Our plan to address the changes is to redeploy employees on a voluntary and "fit-for-role" basis, retrain employees that are identified to be displaced or redundant so that they have new skills to accept new roles or positions, train staff in their current roles to accept new responsibilities or duties, assist staff that are identified as being challenging to place to find comparable positions either within our PPS Partners or in other regional health care facilities, or assist staff who might be released and wish to retire.

Forestland's average turnover ranges from 4% to 12% depending upon the organization, department and facility. Where staffing reduction is inevitable, primarily in our 3 hospitals, the combined effects of redeployment, retraining and natural attrition will meet our strategy to avoid layoffs.

- Describe the PPS' high level approach and strategy to minimize the negative impact to the workforce, including: identifying training, re-deployment, recruiting plans and strategies.

PPS Response (Limited to 250 Words)
To counter the negative impact of changes related to DSRIP on staff, we have engaged a professional services firm to work with us to design and implement a "Total Rewards Philosophy". This change will support consistency and equity as staffing changes are made, and will be accompanied by a sophisticated communication and stakeholder engagement plan. This firm will work with our facilities and partners organizations to design appropriate incentives for existing staff to volunteer for either redeployment and/or retraining.

- Describe any workforce shortages that exist and the impact on the PPS' ability to achieve the goals of DSRIP and the selected DSRIP projects.

PPS Response (Limited to 250 Words)
[Our prototype response was drafted in response to the 29th September version of the application. This bullet point was added after that version, as a response to public comment. Our prototype does not, therefore, include a response to this bullet.]

Scoring Process	This response ***is worth 20%*** of the total points available for *Section 5 – PPS Workforce Strategy*. The response will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.

In the table below, please identify the percentage of existing employees will require re-training, percentage of employees that will be redeployed, and the percentage of new employees expected to be hired. It is expected that a specific project may have various levels of impact to 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
Redeploy	20%
Retrain	20%
New Hire	25%

Analysis of Workforce Impact

Retraining of Existing Staff
Please outline the expected retraining to the workforce, please respond to the following:

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

PPS Response (Limited to 450 Words)
We created a comprehensive workforce strategy – Forestland Health Workforce Strategy (FHWS) to ensure we have the right people, with the right skills, in the right place, at the right time, and the right cost. Our strategy is underpinned by the Forestland Health Future that balances supply and demand for staff to meet the objectives of Forestland and DSRIP. To fulfill our model some employees will be redeployed, retrained, or released. Employees may be asked to accept positions in entities other than their current organization. Our objective is to avoid layoffs. We will leverage existing training programs, intranets, adult learning methods, and media to rapidly retrain staff. We surveyed our partners and overlapping PPS's to identify training resources available to be used, shared, or grown to meet our strategy. We have agreements with local training and educational institutions, e.g., Workforce 1, 4 GFL Community Colleges for nursing recruits, PA, NP, Technicians, and leverage the Area Health Education Center to expand training capabilities. Forestland PPS will conduct a training-needs assessment and select a training vendor(s) to create and deliver training modules. We identified four levels of training: • Level 1. New Organization - Staff who take a position inside or outside their current organization with the skills to perform in their new position, will need training and orientation to different organization, location, shift, department, etc. Curricula may include on-boarding, orientation, on-the job training, diversity training, cultural and language competency, working with an experienced buddy, individual coaching, etc. (20-40 hours) • Level 2. Redesigned Processes - Staff with the technical skills and qualifications to perform the new work processes, will need training on those new processes, including: involvement in

redesign process, formal lean six-sigma training, on-the-job training, coaching, future state processes training, etc. (50 – 80 hours)

- Level 3. New Roles – Staff requested/selected to take a new or vacant management roles such as manager, supervisor, lead, staff, etc. will require training that is complex and take an extended period of time, including: individual coaching, mentoring, 12 month modular leadership training, specialized workshops addressing communication, delegation, planning, monitoring performance, etc. (120 – 400 hours)
- Level 4. New Technical Skills - Staff with little or no knowledge of their new role – college level, intense on the job training and education, orientation, trial deployment, shadowing, etc. An example of this level of training is in use in our pilot community health worker program. (100 to >1,000 hours)

- Please indicate whether the retraining will be voluntary.

PPS Response (Limited to 300 Words)

2 ways we will select staff for involuntary training/retraining:

- Staff remaining in their current department - Workflows and processes throughout the healthcare continuum will be redesigned, changing roles and job functions. Existing employees whose current department/job functions are redesigned will need training to maintain their current position.
- Staff redeployed to different organization/department/location – Redeployment of existing staff represents the quickest most cost effective method to meet future needs of our transformed integrated health delivery system. Staff identified based on the current staff surplus in their existing organization or department and comparing these individuals with existing vacancies. Vacancies will be posted according to Forestland's partners' current workforce policies and procedures and staff invited to apply. HR of their current organization and the hiring manager will determine training needs. Staff in organizations/departments with surplus staff can volunteer for redeployment/retraining for a vacancy. Tenured staff across will have first right of refusal.

- Describe the process and potential impact of this retraining approach, particularly in regards to any identified impact to current wages and benefits to existing employees.

PPS Response (Limited to 150 Words)

Over time, there will likely be fewer staff employed by our PPS and the skill mix will be radically changed. While the FHWS seeks to minimize the impact on the existing workforce while meeting the DSRIP objectives there will be a higher demand for staff in the ambulatory setting. Historically pay in ambulatory settings is lower than in acute care facilities. We will work with HR to determine current salary bands and future state salary bands as a result of up-skilling/retraining/certification. In addition

we will perform any necessary benchmarking of salary bands/overall benefits. In the end we anticipate compensation for 20% of reassigned/redeployed employees will have a decrease in their compensation of between 75% to 95%. Before an individual is offered or selected to retrain, HR of the organizations prepare position packets with a detailed comparison of current and target positions, including location, salary, benefits, role, responsibility, and training. If the new compensation is not <95% of current compensation, the PPS and their partners agree that compensation will remain unchanged.

- Articulate the ramifications to existing employees who refuse their redeployment assignment.

PPS Response (Limited to 100 Words)
Employees who want a role within our PPS will have a role. Staff with the same position titles may be asked to work in a different department or location or even entity. Should they not accept a new position, they will enter the redeployment pool and will have a prescribed amount of time to find a position

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

PPS Response (Limited to 150 Words)
Our PPS is working with labor representatives as partners to design changes that meet the needs of Forestland and unions. MJP is working with the union representatives in completing the training needs assessment. Labor representatives helped develop the Forestland Health Future staffing model and work with the PCC to project staffing needs and placement of displaced individuals.

Scoring Process	This response ***is worth 15%*** of the total points available for *Section 5 – PPS Workforce Strategy*. The response will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.

In the table below, please identify those staff that will be retrained that are expected to achieve partial or full placement. Please identify the percentage of all workers impacted by retraining. 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	40%
Partial Placement	20%

Redeployment of Existing Staff

Please outline the expected redeployment to the workforce, please respond to the following:

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

PPS Response (Limited to 600 Words)

The Forestland Health Workforce Strategy (FHWS) ensures we have the right people, with the right skills, in the right place, at the right time, and the right cost and includes the Workforce Future State Model that identifies supply and demand for staff across all of our partners and facilities. The quickest most cost effective method of filling vacancies is to redeploy staff currently employed within the PPS.

As we make changes to our workforce we want our workforce to be productive. We will engage a Workforce Consultant to review, update the FWFS, and assess the performance of cost centers across all organizations to their targets. The review will ensure that the existing workforce review is up-to-date, uses relevant information and is designed as a tool for planning and staff engagement. We want a five-year strategy to deliver workforce changes including increased productivity, reduced waste, contribution of new technologies, and reduction of headcount. To assure sustainability, the strategy will be reviewed quarterly.

The Consultant will identify departments that must reduce or add staff. We identified 550 FTE in 900 cost centers across 8 organizations that will be over their targets and their budgets as inpatient volumes decrease. We also identified 400 cost centers with staffing needs as well as 680 new positions required to successfully implement the 11 DSRIP projects. We will work with our partner organizations to combine the new position requirements of our DSRIP projects with the current staffing needs to create a detailed matrix of vacancies across Forestland PPS.

During DY1 managers of each department with excess staff will develop plans to meet their targets and identify individuals who might be displaced. Managers will produce a list of individuals, their shift, skill set, job title, and reviewed this list with HR to determine if there are individuals on the list that belonged to protected class. In addition, In the case of poor performance – i.e. individuals with performance ratings below 1 - individuals will be performance managed or released and will not be eligible for redeployment.

Redeployment includes transferring staff to different entities that might typically require hiring to fill the positions. Table 1 below, identifies 6 categories of potential redeployment. Redeployment of a staff member may be to one or any combination of movement to a different facility, department, role, or job classification e.g., Category 1 requires changes to the individual's organization/facility, role, and job class.

Staff remaining in their home department but changing roles and/or job class are not considered to be "Redeployed" and these changes will be coordinated between the department, HR, labor representatives, and the individual. While these changes are voluntary, the individual will understand that remaining in their current role and job class may not be an option.

- Describe the process and potential impact of this redeployment approach, particularly in regards to any identified impact to current wages and benefits to existing employees.

PPS Response (Limited to 150 Words)

Every effort will be made to keep employees "whole". Details will be developed during DY1, but before an individual is offered or selected for redeployment, our intention is that HR will prepare a position packet with a detailed comparison between the current position and the future position, including location salary, benefits, role, responsibility, and training requirement in terms of time. If new compensation is ≤5% lower than current compensation, compensation will not change. We estimate 40% of employees identified for redeployment will have no change to compensation, 40% will have compensation of 95% or greater, and 20% will have compensation between 75% and 95% of their current compensation. We are working with HR and function leads to determine who can potentially be redeployed, and what support will be provided to these staff. We are also coordinating the redeployment process across all PPS members as well as labor representatives to understand and document to what extent redeployment will impact staff compensation and benefits.

- Articulate the ramifications to existing employees who refuse their redeployment "assignment".

PPS Response (Limited to 100 Words)

Our workforce strategy intends that every employee within the PPS partnership who wants a role will be able to have a role at Forestland. Staff with the same position titles may be asked to work in a different organization, department or location. Should they choose not to accept their new position, they will enter a redeployment pool. Staff who are in the pool will be provided access to vacancies across New York State where available. However, every effort will be made to match a Forestland employee with a Forestland vacancy. If a redeployment is refused 3 times the staff may be considered for separation.

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

PPS Response (Limited to 150 Words)

Forestland has a working relationship with labor representatives to help them participate and understand the goals and objectives of Forestland's participation and role as PPS. We will work with

labor representatives to assure that contractual agreements between Forestland and their organizations are understood and respected.

Our FHWS includes a communication plan outlining the need for an agile workforce that reduces the cost of healthcare delivery, accomplishes the objectives of DSRIP, assures our long-term viability, and how the workforce needs to change. It describes what will be done to maintain quality and safety, as well as avoid layoffs. The plan was reviewed and had the input of the labor representatives. The plan is reviewed regularly as circumstances change and includes engagement with staff and unions to deliver the changes. The plan includes communication scripts for different staff groups in an open, honest and meaningful way.

We engage labor representatives when their members are identified for redeployment and/or reclassification. We enlist their support in identifying opportunities for their membership to fill vacancies prior to recruiting on the open market.

Scoring Process	This response ***is worth 15%*** of the total points available for *Section 5 – PPS Workforce Strategy*. The response will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.

New Hires

Please outline the expected additions to the workforce, please respond to the following:

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

PPS Response (Limited to 500 Words)

Our DSRIP projects will create new opportunities. While the exact number of new hires will emerge as we implement our projects, we identified the need to hire approximately 780 staff at many levels, including:

- MD, DO, and Primary care physicians – to expand primary care services for patients in emergency departments and in the community (approximately 50 hires)
- Dentists/Dental technicians – to staff new or redesigned multi-specialty clinics (approximately 30 hires)
- Specialties e.g., Pediatricians, OB/GYN, Oncologists, Surgeons, Podiatrists, – to meet the needs of patients in clinics, multi-specialty clinics, as well as outpatient surgery centers (approximately 100 hires)

- Healthcare navigators / care coordinators – to support patients in effectively navigating the various services that are appropriate for their needs. These will be particularly important for patients / service users with multiple and chronic needs. In addition, they will engage in assertive follow up for particular patient groups and will collaborate with Population Health Management experts in targeting and engaging with low/non-utilizers. (approximately 75 hires)
- Population Health Management experts – to develop, manage, and monitor the creation of an integrated delivery system (approximately 30 hires)
- Human Resources Professionals – to support all of the facilities, department, managers, and staff to effectively redistribute human resources required to implement DSRIP project objectives (approximately 25 hires)
- Case managers – to identify and manage the appropriate length of stay from first encounter of patient in the emergency department of our 14 hospitals to discharge to the appropriate outpatient location or home (approximately 35 hires)
- Social Workers – to increase the guidance and assistance to patients and their families before and after inpatient admission (approximately 40 hires)
- Home health workers – to provide enhanced assistance to patients in their home and decrease un-necessary admissions and re-admissions (approximately 100 hires)
- Allied Health professionals – to staff rehabilitation location and support appropriate care in preparation for patients to be discharged from inpatient facilities (approximately 100 hires)
- Nutritionist – to provide preventative engagement with the population (approximately 15 hires)
- Financial counseling staff – to assist patients in obtaining appropriate financial information and qualification for Medicaid (approximately 5 hires)
- Paramedics and Emergency technicians – early intervention with emergency patients to reduce the time to treat and reduce unnecessary admissions that result from delays in ER (approximately 15 hires)
- Translators/foreign language speakers – to assist with healthcare communication, navigation, diagnosis, chronic disease counseling, etc. (approximately 10 hires)
- RN/NA – to staff expanded primary care services in multi-specialty clinics, clinics, and co-located emergency department primary care services (approximately 30 hires)
- Physician Assistants, Nurse Practitioners and Family Nurse Practitioners – to staff clinics, multi-specialty clinics, emergency departments and co-located emergency department primary care services, as well as post-acute care (approximately 50 hires)

- Communications/marketing professionals– to effectively deliver appropriate messages regarding the changes to Forestland health care delivery (approximately 5 hires)
- Managers/Supervisors – to lead in new or redesigned departments, clinics/facilities, or functions (approximately 10 hires)
- Ambulatory Care practice managers – to manage new or redesigned clinics, multi-specialty clinics, outpatient programs, and post-acute care (approximately 20 hires)
- Mental health specialists, psychologists, MD psychiatrists – to provide expanded Mental Health services to population under DSRIP (approximately 20 hires)
- Process redesign experts – to work with departments/units to design/redesign the workflow, processes, procedures to assure efficient/effective delivery of healthcare (approximately 5 hires)
- Data analysts and statisticians – to provide data collection, analysis, reporting, and monitoring to meet the needs of evidence based medicine, performance management, and DSRIP projects (approximately 10 hires)
- Union/Non-Union – the mix of union/non-union employees is not expected to significantly change

Scoring Process	This response ***is worth 15%*** of the total points available for *Section 5 – PPS Workforce Strategy*. The response will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.

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

Workforce Strategy Budget

In the table below, identify by DSRIP project number 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. The larger the financial commitment to the workforce strategy, relative to the size of the PPS, will have a direct impact on the scoring of this section.

Scoring Process	This response ***is worth 20%*** of the total points available for *Section 5 – PPS Workforce Strategy*. The response will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.

Funding Type	DY1 Spend	DY2 Spend	DY3 Spend	DY4 Spend	DY5 Spend	Total Spend
Retraining	$20,497,500	$17,081,250	$13,665,000	$10,248,750	$6,832,500	$68,325,000
Redeployment	$5,400,000	$4,500,000	$3,600,000	$2,700,000	$1,800,000	$18,000,000
Red	$562,500	$562,500	$562,500	$562,500	$562,500	$2,812,500
Other	$5,348,250	$4,456,875	$3,565,500	$2,674,125	$1,782,750	$17,827,500

State Program Collaboration Efforts

Describe the PPS workforce strategy and how it may intersect with existing State program efforts, please include the following in the response below:

- As applicable, 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.

PPS Response (Limited to 250 Words)

Forestland recognizes that there is a large and ever-evolving number of programs that both NY State and the Federal Government provide to help with training, education, retraining, etc. for health care workers at many levels. To take advantage of these programs, Forestland PPS created a grants and funding working group who identifies government programs and leads the response, application, and submission for funds focused specifically on identified NY State programs. We have identified the need to retrain 548 staff, redeploy 320 staff, recruit 780 staff and will work with The NY State Workforce Investment Board (SWIB) and other State entities to assist in delivering/executing our Workforce Strategy. We have applied for funds from HRSA to assist 15 physicians to cover their education costs in return for working in our underserved area of Northern and Central Forestland.

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. The grants team is monitoring and responding to RFP from Health Workforce Retraining Initiative, dislocated labor training On-the-Job Training/National Emergency Grant, as new rounds of funding become available. In addition, funding and participation in the Shared Work Program and DOH Health Promotion Funds are being pursued. We are currently using the NYDOH's WorkForce 1 program to assist with retrain, and placement of Forestland's staff.

In recruiting physicians into Forestland, preference will be given to graduates from "Diversity in Medicine" programs.

Scoring Process	This response ***is worth 5%*** of the total points available for *Section 5 – PPS Workforce Strategy*. The response will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.

Stakeholder & Worker Engagement

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

- Outline the steps stakeholder engagement process undertaken in developing the workforce strategy.

PPS Response (Limited to 125 Words)
Our workforce steering committee (WFSC) chaired by Margaret Jones EVP-HR at Blackbark Hospital developed Forestland's workforce strategy. The WFSC has 23 members representing HR, hospitals, ambulatory surgical centers, urgent care centers, Health Homes, Community Health Centers, primary care providers, physicians, physician assistants, nurse practitioners, dentists, mental health providers, and rehabilitation services, and representatives from Federation of Nurses/UFT, United Healthcare Workers, Service Employees International Union.

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

PPS Response (Limited to 150 Words)
Our stakeholder analysis determined who needs to be involved and included labor groups, unions, trade groups, etc. 460 interviews were conducted. Attitudes towards retraining, redeployment, recruitment, and retention were surveyed. Employees signed confidentiality waivers, have password protected log-in's to obtain PHI, and built a knowledge sharing site.

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

PPS Response (Limited to 150 Words)
Our communications strategy for the front-line workers includes messaging, timing, media, responsibility, and engagement metrics to mitigate concerns/risks. Surveys, town-hall meetings, the Forestland intranet, on-site visits, teleconferences, etc., will encourage feedback and input.

- 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 to encounter.

PPS Response (Limited to 125 Words)
In a workshop we identified workforce needs by labor group and organization along with opportunities, risks, and ideas. Results were cataloged, summarized, and redistributed for review and comment. The workforce strategy was approved by the WFSC. We developed a communication/engagement plan with messaging, timing, media, responsibility, and engagement metrics. Surveys, town-hall meetings, the Forestland intranet, on-site visits, teleconferences, etc., will encourage feedback and input. Our position control committee (PCC) meets weekly to review, analyze, and approve workforce changes. The PCC resolves staff issues, inability or unwillingness to retrain/redeploy due to age, language, work load, schedule/shift changes, educational requirements, home-work life balance, etc.

Scoring Process	This response ***is worth 10%*** of the total points available for *Section 5 – PPS Workforce Strategy*. The response will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.

Domain 1 Workforce Process Measures

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 that 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 achieving its proposed workforce strategy (Due March 1, 2015).
- Periodic reports, at a minimum semi-annually, providing progress updates on PPS workforce strategy.
- Supporting documentation to validate and verify progress reported on the workforce strategy, such as documentation to support the hiring of training and/or recruitment vendor and documentation to support the development of training materials or other documentation requested by the Independent Assessor.

Section 6 – Data-Sharing, Confidentiality & Rapid Cycle Evaluation

(5% of the Overall PPS Structure Score)

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.

Description

The PPS plan must include provisions for appropriate data sharing arrangements that drive towards a high performing PPS 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.

Data-Sharing & Confidentiality

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 include:

- Provide a description of the PPS' plan for appropriate data sharing arrangement amongst its partner organizations.

PPS Response (Limited to 125 Words)
The transformative change needed in Forestland can only be accomplished with the effective use and sharing of data. Our data sharing & confidentiality plan balances patients' rights to data protection/confidentiality with the need for collaboration and coordination in Forestland PPS. It is based on guidelines set forth by NY State, HIPAA, and the Federal Policy for the Protection of Human Subjects. The approach will be supported by an IT governance structure that will promote the responsible use of data and ensure strict confidentiality.

- Explain the strategy describing how all PPS all partners will act in unison to ensure privacy and security of data, including upholding all HIPAA privacy provisions.

PPS Response (Limited to 125 Words)
In order to support data sharing and confidentiality protocols each of our partners has agreed to accept and sign the following agreements 1) Participation Agreements 2) Forestland Community PPS Business Associate Agreements and 3) Data Use Agreements. The finalization and monitoring of these agreement will be overseen by our IT Governance Committee (see Section 2). Participation Agreement

Ensures that participants comply with data sharing policies and procedures; explains the terms of the relationship, including roles, rights and responsibilities. This agreement will reference the agreements below.

Business Associate Agreement (BAA)
Containing the elements specified at 45 CFR 164.504(e) (use, disclosure and data protection)

Data Use Agreement (DUA)
Describing in further detail what the shared data will be used for, including additional safeguarding regulations.

- 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.

PPS Response (Limited to 250 Words)

Partners in our network with paper-based systems will be offered several options to move to an electronic platform: 1) FCPPS offers an EHR-light version to all partners; 2) Each partner secures a compatible EHR platform through a vendor selection process (using the secure SHIN-NY / RHIO infrastructure to link these EHRs, allowing real-time data access). As the transition to an EHR platform will be a multi-year process, we facilitate non-(compatible) EHR partners to share core data elements with the PPS, drawing upon the SHIN-NY / RHIO infrastructure, so that mid DY1 we will be able to share the core data elements required for the successful patient management and outcome monitoring in the projects we selected. The graph included in the Appendix displays how real time information will be accessed.

We have included protocols and guidance within our strategy to support staff in making the patient consent process a central part of the patient / provider relationship. In light of the significant disruption this transition (a true behavioral change) will involve for clinicians and managers alike we have established a communications and change management plan that will span the life of the DSRIP program and identified staff to implement and develop this plan over time. Significant education and training is a core part of that plan, which includes the ability to understand the required analytics and performance monitoring that will become part of our emerging virtual integrated delivery system (see also the next subsection). These training needs have been accounted for in our workforce strategy.

Scoring Process	This response ***is worth 50%*** of the total points available for *Section 6 – Data Sharing*. The response will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.

Rapid-Cycle Evaluation

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.

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

- Identify the organizational unit 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 unit to the PPS' governing team.

PPS Response (Limited to 150 Words)
We interpret 'rapid-cycle evaluation' as the approach to Performance Management that will be a core operating principle for our PPS (see also our Governance Section). Moving towards the years in which the DSRIP payments will become based on outcomes, and the Value-Based Payment arrangements that will equally be outcome-based, we see the need to be 'in control' of our DSRIP metrics as a core capability to develop. Becoming 'in control' of outcomes implies the joint development of four building blocks at PPS level: (1) a culture devoted to optimizing outcomes for patients; (2) clear responsibilities and accountability of staff for these outcomes; (3) optimizing and standardizing processes that we deem vital to realize these outcomes and (4) continuous measurement of these outcomes and the process-metrics that drive these outcomes. This approach to Performance Management will be driven jointly by our Clinical and Financial Governance Committees; per individual project, one or two key individuals will be appointed who will be responsible for the realization and continuous improvement of the trans-organizational, multi-disciplinary care pathways underlying the project. Simultaneously, these individuals will be held (jointly) accountable for the project's clinical and financial outcomes. (In the first 2-3 years, these financial outcomes will be 'virtual': using estimates of potential changes in total cost of care for the target populations; in the latter years, we aim to create value-based payment arrangements with our ACOs so that these financial results become equally real as the clinical outcomes achieved). These individual report to the Clinical and Financial Governance Committees respectively.

- Outline how will the PPS intends to use collected patient data to:
  - Evaluate performance of PPS partners and providers;
  - Conduct quality assessment and improvement activities; and
  - Conduct population-based activities to improve the health of the targeted population.

PPS Response (Limited to 125 Words)
As described in the Governance section, FHPP will use its MAPP PPS specific Performance Measurement Portal for the monitoring of its performance on the claims-based, non-Hospital CAHPS DSRIP metrics, as well as the DSRIP population health metrics. This portal (which will go live during DY1) will also show our

performance vis-à-vis baseline information, benchmarks, and the gap-to-goals targets per metric. We will develop our own PPS-wide Performance Measurement system for the Medical Record-based measures, as well as for those process measures that our project development groups are identifying as driving the outcomes we aim to realize. We are currently discussing with our MCOs to exchange key information (including additional quality metrics) that will be mutually beneficial. With these sources, we will have both long-term and sufficiently timely information available. We will use sophisticated Statistical Process Control methods to capture emerging unfavorable trends at the earliest moment possible.

- 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?)

PPS Response (Limited to 125 Words)
A summary dashboard will be made available for the monthly Executive Board reports, showing on 1 (digital) page the overall performance of the PPS. Drill-down capabilities, with dedicated dashboards for the Financial and Clinical (sub) Committees, will be available as well.

- Explain how the RCE will assist to facilitate in the successful development of a highly functioning PPS.

PPS Response (Limited to 125 Words)
We are aware that this performance management approach, which will be embedded in our broader IDS project, is deeply transformational. We are convinced that 'hardwiring' this approach in both the organizational as well as the technical infrastructure of our PPS will proof to be a key to our success.

Scoring Process	This response ***is worth 50%*** of the total points available for *Section 6 – Data Sharing*. The response will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.

Section 7 – PPS Cultural Competency/Health Literacy

(15% of the Overall PPS Structure Score)

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.

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.

Approach to Achieving Cultural Competence

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, health care that is respectful of and responsive to the needs of diverse patients. 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:

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

PPS Response (Limited to 250 Words)
The PPSs in Forestland have a shared commitment to reducing health disparities between different cultural and ethnic groups and improving access across the region. This is particularly significant for the Forestland Health PPS because of its large amount of cultural diversity. The different cultures and cultural beliefs throughout Forestland can affect: - Patients' willingness to access services (for example, our CNA demonstrates that access to most services is limited for undocumented immigrants and the fear of deportation results in lower utilization of services); - Their lifestyle choices, such as diet, sleeping patterns, work-life balance, and substance use/abuse; and

- Their beliefs about healthcare and healthy behaviors and beliefs that may affect patients' willingness to access care (particularly sexual health).

- 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 addressing how the PPS will engage and train frontline healthcare workers in order to improve patient outcomes due to cultural competency challenges.

PPS Response (Limited to 250 Words)
Different cultural groups in Forestland are often concentrated in specific areas – e.g. the concentration of European-language-speakers in Juniper Hill. Our approach to creating culturally-competent organizations and services will therefore be to provide incentives for providers to develop culturally-appropriate services whilst giving them the freedom to decide what will have the greatest impact for their specific communities. To create these incentives, we will: - Measure disparities in outcomes for different cultural groups; monitor progress on reducing these disparities; and publish the results to encourage peer-pressure and best practice sharing - Adopt National Standards for Culturally and Linguistically Appropriate Services - Provide guidance and best practice to providers about which aspects of service delivery they should consider - Hire and train staff representative of their patient population – through the Forestland Health Workforce Strategy (FHWS) - Through the FHWS, offer training to staff – front-line staff and executives – about the healthcare-specific beliefs of different communities and religions and how they affect service design

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

PPS Response (Limited to 250 Words)
[Our prototype response was drafted in response to the 29th September version of the application. This bullet point was added after that version, as a response to public comment. Our prototype does not, therefore, include a response to this bullet.]

Scoring Process	This response ***is worth 50%*** of the total points available for *Section 7 – Cultural Competency & Health Literacy*. The response will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.

Approach to Improving Health Literacy

Health literacy is "the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions". Individuals must possess the skills to understand information and services and use them to make appropriate decisions about their healthcare needs and priorities. Health literacy incorporates the ability for 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.

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

- Describe the PPS plan to improve and reinforce health literacy of patients served.

PPS Response (Limited to 250 Words)
Approximately 1% of Forestland's population entered the US in the last year. Around 25% speak English less than "very well"; nearly half speak a non-English language at home. This creates challenges around patients not understanding how to access/navigate the system and relying on emergency care. Poor awareness of preventive services leads to patients accessing care late, once a condition has exacerbated. In line with our approach of incentives and local flexibility, we will: measure disparities in effective access and healthy behaviors between cultural groups; monitor progress on improving these measures; and publish results, encouraging peer-pressure and best practice sharing.

- Indicate the initiatives that will be pursued by the PPS to promote health literacy. For example, will the PPS implement health literacy integral to its mission, structure, and operations, has the PPS integrated health literacy into planning, evaluation measures, patient safety, and quality improvement, etc.

PPS Response (Limited to 250 Words)
To support providers, we will: - Provide guidance and best practice about how they can engage with their local community about health risks and benefits and how people can make better decisions

- Require providers to conduct assessments of their facilities & services, focusing on:
  - Environments where patients are not "blamed" for low health literacy
  - Ease of use of forms and processes, with attention to format and reading level for non-English speakers
  - Leveraging existing community groups (e.g. churches) to improve health literacy
- Provide 'core' health promotion and system navigation literature in multiple languages that can be tailored by providers to meet their specific needs
- Hire and train staff representative of their patient population – through the FHWS
- Adopt National Standards for Culturally and Linguistically Appropriate Services
- Improve the reliability and validity of data to assess disparities in outcomes related to health literacy and cultural differences.

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

PPS Response (Limited to 250 Words)
[Our prototype response was drafted in response to the 29th September version of the application. This bullet point was added after that version, as a response to public comment. Our prototype does not, therefore, include a response to this bullet.]

Scoring Process	This response ***is worth 50%*** of the total points available for *Section 7 – Cultural Competency & Health Literacy*. The response will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.

Domain 1 – Cultural Competency/Health Literacy Milestones

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 that 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.

Section 8 – DSRIP Budget & Flow of Funds

(Pass/Fail with No Scoring)

Scoring Process	Pass/Fail. 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.

Description

The PPS will be responsible for accepting a single payment from DOH tied to the organization's ability to achieve the measurable goals of the DSRIP projects. In accepting the performance payments, the PPS must establish a plan to allocate the DSRIP funding amongst the participating providers in the PPS. In the response below, please address the following on DSRIP budget and flow of funds:

- Describe the plan in which the PPS plans on distributing DSRIP funds.

PPS Response (Limited to 125 Words)
The DSRIP Funds Distribution Plan establishes six budget categories through which the DSRIP funds are distributed. The expected budget amounts are based upon the initial project level budgets and the project specific implementation costs. The distribution plan allows for certain categories of costs, such as implementation, to be more fixed while adjusting to varying levels of performance and goal achievement. The distribution plan allocates significant funds to support providers for revenue loss and costs related to redesign initiatives. The plan also provides bonus payments for providers to achieve their project goals and to support the attainment of the broader PPS goals. The DSRIP funds plan also provides measures to ensure that the Safety Net Providers receive 95% or more of the distributed 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 (LHCSAs), and adult day health care (ADHC) programs

PPS Response (Limited to 125 Words)
The distribution of DSRIP funds is guided down to the provider level initially by project budgets which define the costs and goals for each of the participating providers. Within each of the categories applicable to a specific provider, the provider is assigned a participation percentage which represents the budgeted amount of DSRIP funds that the provider is eligible to receive. This percentage is influenced by the valuation of the DSRIP projects chosen overall by the FHPP with consideration of the project related costs and support that may be needed by the provider such as current revenue streams or funding sources being negatively impacted by DSRIP projects.

- Outline how the distribution of funds is consistent and/or ties to the governance structure.

PPS Response (Limited to 125 Words)
The Executive Body of FHPP has full representation of the provider groups and providers within the committees and workgroups that are responsible for the selection and approval of DSRIP projects and goals. This representation of all providers and clinical specialties within the governance structure ensures that DSRIP funds flow to the projects consistent with the DSRIP goals and finally to those providers responsible for achieving the goals for each of the DSRIP projects and for the overall DSRIP initiative.

- Describe how the proposed approach will best allow the PPS to achieve its DSRIP goals.

PPS Response (Limited to 200 Words)
The FHPP's plan for distribution of DSRIP funds supports achievement of its DSRIP goals by rewarding participation in DSRIP projects and achievement of goals determined to be consistent with FHPP's DSRIP objectives. Further, the plan sets aside funds for revenue loss and to support financially challenged providers in becoming financially stable. The FHPP plan also rewards high performers who exceed metrics while at the same time providing for penalties for providers who consistently fail to meet agreed upon targets or their restructure plan objectives. The FHPP plan also provides a mechanism to allocate statewide reductions in DSRIP funds due to poor performance provides incentives for providers to work with managed care organizations to implement value based payment mechanisms to ensure the sustainability and expansion of the DSRIP program initiatives. The Budget Distribution Matrix included herein outlines the plan for how the DSRIP funds will be distributed with the percentage of payments the FHPP expects to distribute to each with attainment of 100% achievement in each of the categories.

Scoring Process	Pass/Fail. This section is not factored into the scoring of the PPS application. This response will be evaluated for completeness and a pass/fail determination will be made based upon the quality of the response.

To summarize the methodology, please identify the percentage of payments PPS intends to distribute amongst defined funding distribution categories. Funding distribution categories must include (but are not limited to):

1. **Cost of Project Implementation:** the PPS should consider all costs to be incurred by the PPS, such as salary and benefits, contractor costs, materials and supplies, and its participating providers in implementing the DSRIP Project Plan.

2. **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. In addition, funding can be distributed based upon providing the necessary funding to sustain the safety net.
3. **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	Percent
Project Implementation Costs and Administration - Implementation and transformation costs - Investments required to realize project goals - DSRIP Office, Central PMO and Administration of PPS and PPS Lead	15%
Costs for services not covered - Services which are essential to DSRIP project goals but not reimbursed, or are not sufficiently reimbursed, by Medicaid - Community care, social services, housing, transport or other services	10%
Revenue Loss - Reduction in Services including reduction in bed capacity, redundant procedures, closure of delivery sites - Financially fragile providers needing support during restructure or programs - Safety Net providers requiring support through transition period	20%
Bonus Payments - Payments for achieving DSRIP project goals - Payments to incentivize achievement of core DSRIP goals and milestones - Incentives to achieve financial restructure or stability goals	45%
Contingency Fund - Reserve fund to set aside for unexpected costs or events - Allow for reductions due to Statewide missed DSRIP goals - Set aside for providers whose "missed" goals are within an acceptable variance with an incentive to close the gap	5%
Other - High Performance payments - Recognition of high performance achievement within the PPS - Mechanism to stimulate new and innovative ideas across the PPS and the community	5%
Total	100%

Domain 1 – Project Budget & DSRIP Flow of Funds Milestones

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 that 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.

Section 9 – Financial Sustainability Plan

(10% of the Overall PPS Structure Score)

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.

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 and operational strategies 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 an operating model that will support the financial sustainability of the PPS throughout the five year DSRIP demonstration period and beyond.

Assessment of PPS Financial Landscape

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

PPS Response (Limited to 250 Words)
The Forestland Health Provider Partnership (FHPP) completed an initial survey of potential PPS providers identified as part of the Community Needs Assessment (CNA) phase. The survey respondents provided financial and income related data, financial and operational metrics, statistics related to payer mix and utilization trends as well as narrative responses to specific questions regarding the providers' use of, or dependencies on, sources of funding for uninsured or indigent services that might or will be impacted by DSRIP such as support payments received from government and non-government sources, bridge money, or debt guarantees. (Individually operating professionals were only asked for some core characteristics). The response from these PPS providers included a Sensitivity Analysis developed by the FHPP to model the financial impact that reductions of 10%, 15% and 25% in the provider's DSRIP targeted utilization would have on the financial stability of the provider. Further, larger providers (especially hospitals and nursing homes) whose absence, or whose failure during the DSRIP period would be disruptive to the overall performance of the PPS in achieving the DSRIP goals, were identified and then asked to provide additional financial and operational data. Then, working with the Executive, Financial and Clinical leadership of the provider, the FHPP completed additional sensitivity and cash flow analysis of these potentially fragile provider organizations in order

to identify those which were at the time financially distressed as well as those that could, based on current status or trends, become financially distressed due to their participation as a PPS provider.

- Identify at a high level the expected financial impact DSRIP projects will have on financially fragile providers and/or other providers that could potentially negatively impacted by the goals of DSRIP.

PPS Response (Limited to 500 Words)

Hospitals, nursing homes and other (primarily) inpatient-focused providers will be negatively impacted by the DSRIP goals. The impact may vary depending upon their current service delivery and business model and the extent to which the current 'gap to DSRIP goal' is more or less significant. The DSRIP projects will have a greater negative impact on those providers who fail to implement the changes in their business and operating models which are required for the provider to succeed as part of an integrated delivery network as intended by the implementation of DSRIP. Of course, such financial impact will be felt more acutely by those providers already identified as being financially fragile.

FHPP also anticipates that those providers who have traditionally received some level of support payments, bridge money or debt guarantees from the State through the Distressed Hospital Pool, Grant Programs, or other sources of funds, will be negatively impacted by the overall reduction in these funds – whether or not related to DSRIP. While there are provisions in the DSRIP program for certain providers to access funds to assist during the transition to DSRIP, such as IAAF and Medicaid Redesign Funds, it will be essential for providers who are distressed financially to quickly implement the changes identified as part of the FSP or their Distressed Provider Plan.

There are a number of ways that the DSRIP projects could potentially impact providers overall and particularly those who are already determined to be financially fragile, including:

- Reductions in inappropriate admissions and ED volumes could impact acute care providers depending upon their cost structures and payor mix for a period of time until the payment mechanism transitions to value-based payments
- Reduction in available cash, particularly in the short term due to the loss of support payments or to the lower levels of reimbursement especially for disproportionate share providers.
- Requirements to reduce or eliminate services will result in higher short term costs related to the discontinued services for closure and labor force reduction. The provider will also experience challenges within their market responding to pressures regarding reductions that must be funded.
- Reductions in utilization of certain levels or types of services may be partially offset by increases in levels of care that are part of the DSRIP project continuum. However, costs related to staffing and skill transitions, as well as any capital requirements related to the transition may have a negative impact during the initial phase of implementation.

- A failure or inability of a provider to meet plan requirements for the reduction in services and the reduction in related operating expenses will have a negative impact particularly during the initial operating periods as providers progress toward achieving DSRIP project goals.
- Timing differences in the flow of funds today in the form of direct payer payments as compared to the flow of cash from the distribution of DSRIP funds could impact providers.

The FHPP is making specific provision in the budget and funds flow plan to support Safety Net and Vital Access providers, especially those who are financially challenged and to support their efforts at implementing change through the FHPP PMO.

Scoring Process	This response ***is worth 33.33%*** of the total points available for *Section 9 – Financial Sustainability Plan*. The response will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.

Path to PPS Financial Sustainability

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:

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

PPS Response (Limited to 300 Words)

The FHPP will develop a Financial Stability Plan (FSP) during the initial implementation and startup of the PPS. The FSP will be developed under the oversight of the Finance Committee and presented to the Executive Body for approval during the January 12, 2015 scheduled meeting. A key to achieving financial stability for any provider is to operate within healthy metrics and to achieve key milestones in the organization's financial and operational plan. The FSP will define the specific financial and operational metrics that must be achieved during each phase of the DSRIP project in order for the FHPP to be financial stable and for the DSRIP goals to be met, it will include a process to monitor and report actual results compared to the metrics, and will specifically identify providers whose responses to the Community Needs Assessment survey indicated that they were, or could become, financially challenged.

Rosewood has presented their restructure plans to the FHPP Finance Committee. FHPP will work with Poplar Medical Center to create a restructuring plan that will have to be accepted by the Finance Committee and the Executive Body before April 1st of 2015. The plans focus on expense reduction, restructure of debt, re-allocation of resources, and re-alignment of services to meet DSRIP goals. In the case of Poplar Medical Center, the changes needed to achieve financial stability are more significant due to the need to reduce excess capacity in an already financially fragile institution. At this time we do not believe these efforts will have a material impact on the ability of the provider to participate in the PPS but will continue to monitor the status of these providers through their reports to the FHPP Financial Committee.

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

PPS Response (Limited to 150 Words)
The FHPP budget and flow of funds plan will provide for needed support of fragile safety net providers, and will provide for support of other providers, who are achieving agreed upon metrics but who require additional support especially during the critical Year 1 transition period. If these provider indicate a trend that could impact their financial stability, a Distressed Provider Plan will be developed and managed by the PPS PMO.

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

PPS Response (Limited to 150 Words)
During the DSRIP period, FHPP will begin collaboration with other managed care organizations as a way of taking the lead in making performance-based programs a part of the broader healthcare delivery system and operating model. FHPP will assist these organizations in developing programs that reinforce provider and patient roles in quality based population health management. We believe that during the DSRIP period the continuum of services, and the coordination of that continuum, will have contributed to a healthcare services market with providers who have matured as a population and disease management organizations who are responsive to quality and outcomes models under a value based rewards methodology. This will enable these providers and their organization to mature into a financially sustainable organization and to sustain the programs and services that will benefit their organization and the patient population beyond the 5 year DSRIP period.

Scoring Process	This response ***is worth 33.33%*** of the total points available for *Section 9 – Financial Sustainability Plan*. The response will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.

Strategy to Pursue and Implement Payment Transformation to Support Financial Sustainability

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

- 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.

PPS Response (Limited to 200 Words)
Meaningful and lasting payment reform will be critical to ensure that the Forestland PPS and our project initiatives are sustainable during and beyond the 5 year demonstration period. Forestland

Health, the lead of the Forestland PPS is already well versed in payment reform initiatives and has actively led in some smaller areas of payment reform, including risk-based payments for routine acute surgeries and sub-capitation arrangements with our largest MCO. Likewise, several of our PCMHs have experience with capitation-based payments.

Our visions for a value based payment model will be a payment system that is transparent, fair, and increases the quality of health services provided by our PPS, while rewarding high performance. To be successful, it must be scalable and flexible to allow all our networks providers, who are at a variety of stages in payment reform, to participate and allow for multi-year phasing. There are four Medicaid Managed Care (MMC) plans and two HIV Special Needs Plans (SNPs) serving our communities. We will continue to engage with the MMCs in this process, specifically developing a plan for what services will move to episodic or continuous care bundles.

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

PPS Response (Limited to 300 Words)

We are particularly interested in shared savings opportunities. We believe that our projects will drive down (re)admissions and other avoidable complication related costs so that at the total cost of care level, the total amount of current Medicaid payments per patient would be reduced. Partially, these reductions in income can be compensated by DSRIP income, but structurally, we believe shared savings models (where savings are shared by DOH, the MCO and the PPS) will drive a much more efficient, effective and sustainable way forward. For example, as long as the total state Medicaid expenditures remain under the Statewide Cap, the MCO could set the target threshold at 2% below current cost (historical cost, perhaps adjusted by a statewide risk-adjusted benchmark), receiving 3% of additional savings while re-allocating 95% of the shared savings under the threshold to the PPS and/or its individual partners.

Rather than opting for a total capitation model for the whole PPS (effectively transferring (most) insurance risk to the providers), we would prefer models in which we realize shared savings VBP arrangements for certain bundles of care: we are currently studying the possibility of a chronic Diabetes and Cardiovascular Care bundle). Also, the full capitation of our PCMHs, with shared savings linked to the reduction of 'downstream' costs, appears to us as a win-win model for DOH, MCOs and our PPS. In addition, we would like to discuss with DOH the ability to assume full risk for both the HARP and Health Home populations in our community, and introduce an integrated Maternity care bundle. Although we do not feel we will be ready to assume both upside and downside risk before DY4 for most of these initiatives, we are confident that we will be ready to engage in upside-risk only shared savings arrangements by DY2 (as a glide-path towards up- and downside risk arrangements).

Scoring Process	This response ***is worth 33.33%*** of the total points available for *Section 9 – Financial Sustainability Plan*. The response will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.

Domain 1 – Financial Sustainability Plan Milestones

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 that 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 detailed implementation plan on the PPS' financial sustainability strategy (due March 1, 2015); and

Quarterly reports on and documentation to support the development and successful implementation of the financial sustainability plan.

Section 10 – Bonus Points

Proven Population Health Management Capabilities (applicable to Project 2.a.i. only)
Population health management skill sets and capabilities will be a critical function of the PPS lead to successfully develop an integrated delivery system. 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.

Scoring Process	If the response can effectively demonstrate the PPS Lead or partners has proven population health management capabilities, particularly with the Medicaid population, the PPS will be awarded ***3 additional bonus points*** to the 2.a.i. project application score.

PPS Response (Limited to 250 words)

Proven Workforce Strategy Vendor
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.

Scoring Process	If the response can effectively demonstrate the PPS Lead contracted with a proven and independent organization to assist the workforce strategy the PPS will be awarded ***3 additional bonus points*** to each project application score.

PPS Response (Limited to 250 words)
The workforce strategy represents a significant lever to achieve the goals of DSRIP. Forestland PPS concluded that neither its Lead Provider, nor the aggregate of its Partner organizations have the capacity and expertise to manage the complexities of the planned changes alone. In February Forestland issued an RFI. Five firms were selected to submit proposals. In June we selected ABC Workforce Consulting to manage and monitor the workforce strategy, conduct our workforce needs assessment, source specialist expertise in compensation, wages, benefits, HR process, recruitment, retention and training, to develop and implement a "Total Rewards Strategy", and review and revitalize our HR policies and procedures. ABC Workforce Consulting has helped health care organizations optimize their performance by: managing teams to drive business performance; enhancing compensation and benefits through a total reward philosophy; enhancing HR effectiveness. ABC Workforce Consulting has a proven record of managing large-scale workforce transformation programs.

ABC Workforce Consulting has 13,000 employees in 160 cities worldwide, including 2,652 partners (1,600 in USA). ABC Workforce Consulting has led major reorganizations, workforce transformations, joint ventures, and merger integration. They have dedicated, experienced consultants with specific healthcare industry expertise.

ABC Workforce Consulting will provide resources throughout the transformation, from planning through to integration and execution, including specialized human resource expertise to focus on implementing changes. They use a collaborative approach to address challenges and opportunities and proprietary tools to support their work. They will partner with Forestland to provide analytical support for all people-related policies and programs and provide guidance in managing and deploying the workforce to meet the needs of DSRIP.

Selection of 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)
As previously articulated by DOH, the bonus points will be attributed to those PPSs that have elected to pursue the 11th project.

Scoring Process	Those PPSs that have elected will be awarded ***additional bonus points*** to each project application score.

Please indicate whether the PPS has elected to pursue the 11th project by marking the appropriate box below.

Yes	No
X	

Section 11 – Attestation

The lead applicant of the Performing Provider System [PPS] must sign this attestation form in order for the project application to be valid.

Check the following:

☑

I hereby attest as the lead applicant of this PPS that all information provided on this Project Plan Applicant is true and accurate to the best of my knowledge.

Lead Provider Name: Forestland Health Hospital Center

Name of Authorized Officer: April Greenthumb

Date: November 14th 2014

Disclaimer

This document was prepared by the Delivery System Redesign Incentive Payment (DSRIP) Support Team (DST). The advice, recommendations and information in the document included with this notice were prepared for the sole benefit of the New York State Department of Health, based on the specific facts and circumstances of the New York State Department of Health, and its use is limited to the scope of KPMG's engagement as DST for the New York State Department of Health. It has been provided to you for informational purposes only and you are not authorized by KPMG to rely upon it and any such reliance by you or anyone else shall be at your or their own risk. You acknowledge and agree that KPMG accepts no responsibility or liability in respect of the advice, recommendations or other information in such document to any person or organization other than the New York State Department of Health. You shall have no right to disclose the advice, recommendations or other information in such document to anyone else without including a copy of this notice and, unless disclosure is required by law or to fulfill a professional obligation required under applicable professional standards, obtaining a signed acknowledgement of this notice from the party to whom disclosure is made and you provide a copy thereof to the New York State Department of Health. You acknowledge and agree that you will be responsible for any damages suffered by KPMG as a result of your failure to comply with the terms of this notice.