CNY CARE COLLABORATIVE

CNY Coordinated Care Network DSRIP Application Findings

Transitions of Care Assessment

Deloitte Consulting LLP

December 2, 2014

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Preface

Deloitte Consulting LLP was engaged to support Upstate University Hospital, in their role as the lead for the Central New York Care Collaborative, in the assessment of the market and development of materials related to the DSRIP project. This document is intended to address the various deliverables as noted in "Deloitte Consulting LLP's Proposal to Provide Transitions of Care and Care Coordination Services in Support of Upstate University Hospital's DSRIP Application Development" dated August 27th, 2014.

Transitions of Care Proposal Deliverables

Item	Deliverable	Key
1.a.	Collect and analyze data on PPS to inform current state and capabilities	
1.b.	Results of PPS Care Transitions assessment including current state capabilities and gaps	
1.c.	Identify key partners to be interviewed and will confer with CCCN on suggested individuals to generate a final list.	
1.d.	Outcome of interviews with recorded responses to key questions	
1.e.	Analyze and synthesize key themes from partner interviews	
2.a.	Utilize HVNT to further analyze existing care integration network and identify gaps in network and potential partners	
2.b.	Compile information and data analysis to highlight strengths, capacity, and potential gaps	
2.c.	Summary of capacity findings and recommended next steps	
2.d.	Report on PPS strengths and gaps identified through secondary data source analysis	
3.a.	Develop partner grading tool to assess each partner's capabilities and fit and assist in determining key gaps	
3.b.	Key partner assessment criteria and decision tool	
3.c.	Recommendation for PPS partner list supplemented with partner information, scoring sheet, potential benefits	
3.d.	Results, key themes, and preliminary recommendations from the network survey	
4.a.	Using Deloitte knowledge tools and resources (SMAs, etc.), develop potential future state scenarios based on current state, market conditions, and selected DSRIP projects	
4.b.	Targeted and well-defined organizational and cultural change management strategy recommendations	
4.c.	Recommendations for initiatives to mitigate potential gaps identified through the assessment	
4.d.	Construct a high level implementation roadmap for client validated initiatives to achieve recommended future state	

Contents

Interview Findings

The following interview key findings, observations and implications are aggregated themes which were found to be consistent across many of the stakeholder interviews conducted between October 6th and October 29th. Throughout this period Deloitte engaged in 29 individual interviews with 20 unique organizations and over 40 stakeholder participants. Outside of the individual interviews, many of these findings were further corroborated or generated from the October 21st PAC meeting in which more than 60 unique organizations were registered.

Key Interview Findings

	Key finding	Observations	Implications
People	**Significant cultural issues exist that are a barrier to change and patient-centered care**	• Physician engagement is currently insufficient to drive change • Teaching responsibilities at the academic medical center has limited patients' access to primary care	• Physician engagement will be critical to the success of the DSRIP program • The primary care network in the community should be strengthened to improve access to care
	Existing community relationships should be leveraged wherever possible	• Many resources in the community exist but they are not being promoted/communicated effectively	• CNYCC should leverage existing relationships in the community instead of overlaying a new structure as part of the DSRIP efforts
Process	**Collaborative and consistent discharge processes are critical to success**	• The differing models of care in pediatric vs. adult programs can lead to challenges when patients transition from one program to another • Discharge processes are not standardized • Community resources should be involved much earlier in the process • Lack of timely access to outpatient care for Medicaid members	• Standardizing discharge procedures would facilitate continuity of care across DSRIP partners • Expanding the role of community resources in discharge processes would improve follow up care after hospitalization by improving communication between caregivers
	There are unique regulatory barriers for this population	• Regulatory issues can be prohibitive to comprehensive care delivery (i.e. prior authorizations, scope of practice, DVS, etc.)	• Regulatory barriers must be taken into consideration in the DSRIP project plan design in order to ensure the providers get reimbursed

Note: Interview findings and observations are derived from the key stakeholder interviews conducted and may or may not be substantiated with further data analysis or research

Key Interview Findings

	Key finding	Observations	Implications
Technology	**Huge need for data sharing and analytics capabilities**	• A large percentage of organizations have electronic data available, but the ability to share data between entities rarely exists • Risk stratification occurs in few organizations and should be more consistent and comprehensive	• Data sharing would facilitate DSRIP resource planning and priorities based on the needs of partner organizations and goals
	Communication between all providers involved in care of a patient is critical	• Coordinated care plans do not exist across all providers involved in care of a single patient which will be critical to success • Telehealth is being used by many of the providers already	• Communicating patient care plans to all providers will remain critical to reducing unnecessary care and preventable adverse events

Note: Interview findings and observations are derived from the key stakeholder interviews conducted and may or may not be substantiated with further data analysis or research

Shared Vision and Goal Alignment

The Shared Vision and Goal Alignment assessment is a unique look at 22 select interviews conducted by the Deloitte team, focusing specifically on organizational and cultural implications. In addition to the interview notes reviewed, many themes were captured during the Governance and Work Force Strategy breakout sessions of the October 21st PAC meeting.

Executive Interviews – Summary of Key Findings

Vision / Mission / Strategy & Goal Alignment	▪ There is a high amount of alignment among leaders due to the incentives provided by DSRIP; however, competition and overlapping initiatives with other PPS' could serve as barriers to success. ▪ Healthcare leaders have a clear understanding of DSRIP, but additional education is needed for physicians and community members. ▪ Leaders recognize that focusing on care coordination is a step towards patient-centered care that will require more emphasis to be placed on leveraging community resources over inpatient services.
Leadership	▪ Leaders note that lasting change needs to be driven "top down", from leaders throughout the organization. ▪ Leaders from the insurance companies have been unwilling to get involved with the initiative to date – if this group is not engaged, they could case a significant barrier in the future.
Workforce Management	▪ It was consistently mentioned that care teams need to be utilized more frequently and more effectively. ▪ There is believed to be a disconnect between clinical education and practice, which could be a barrier to coordination and integration. ▪ The healthcare industry is changing at a rapid pace, and the workforce is feeling "change fatigue". ▪ Leaders are concerned that many Primary Care Physicians (PCPs) are unwilling to take Medicaid patients, or patients with histories of behavioral health challenges. ▪ There is a need to secure the "right" talent to ensure the DSRIP initiatives are successful.
Culture	▪ Overall, it was noted that Upstate is slow to change and to make decisions. ▪ Leaders emphasize that a shift is needed from a physician-centered model to a patient-centered model. ▪ Past behaviors around engaging home care could cause challenges with care coordination. ▪ Communication is a key part of coordinating care and needs to be enhanced in a variety of ways. ▪ It can be a challenge to meet the language and cultural needs of diverse populations throughout New York.
Organization Agility	▪ Leaders agree that there is a lack of capacity in ambulatory clinics throughout Central New York. ▪ The transitions between pediatric care and adult care have proven to be difficult to orchestrate. ▪ Regulatory issues can be prohibitive to comprehensive care delivery. ▪ Technology was often cited as a barrier to coordinated care.

Note: Interview findings and observations are derived from the key stakeholder interviews conducted and may or may not be substantiated with further data analysis or research

Executive Leadership Interview Detailed Findings by Dimension

Vision / Mission / Strategy & Goal Alignment

- Leaders agree that the care coordination effort is a **step in the direction of patient-centered care**.
- The incentives offered through DSRIP have created a **high amount of alignment among leaders** for the care coordination initiatives. However, there does appear to be some alignment needed **utilizing existing services versus "recreating the wheel"** through these new initiatives.
- Leaders recognize the need for an overall **shift in focus from relying on inpatient services to leveraging the full continuum of community services** available, to avoid unnecessary admissions and provide the best care to all patients in need. Providers should serve as a "gateway" into the overall community resources.

Leadership

- Healthcare leaders throughout Central New York have a good understanding of DSRIP, but **additional education is needed for physicians and community organizations**.

Workforce Management

- The leadership team agrees that coordination among providers is important, but recognizes that **patients' engagement in their own health is also key to success** (e.g., patients need to take responsibility for informing PCPs if they have just been discharged from the hospital).

Culture

- **Physician engagement is frequently cited as a barrier** to the success of care coordination.
  - Additional physician education is needed around DSRIP and key contributors to coordinated care, such as the importance of utilizing home-based services.
  - Incentivization models may be perpetuating the collaboration challenges among physicians (e.g., the length of stay score is attributed to the physician who orders the discharge).
- Similar, or overlapping, PPS initiatives should be coordinated with the DSRIP efforts to **avoid cannibalizing resources and time** (e.g., the Frequently Admitted Patients program).
- Leaders recognize that **competition among providers within a PPS could be a barrier to success.**

Organization Agility

- The **needs of the local communities may vary across the State of New York** and could result in a fragmentation of goals and strategies.
- Some leaders note that **the availability of capital** may prevent the attainment of DSRIP goals.

Note: Interview findings and observations are derived from the key stakeholder interviews conducted and may or may not be substantiated with further data analysis or research

Executive Leadership Interview Detailed Findings by Dimension

Vision / Mission / Strategy & Goal Alignment

Leadership

Workforce Management

Culture

Organization Agility

- **Leaders note that lasting change needs to be driven from the top down**.
  - Hospital administration and the Departments of Medicine need to set the behaviors, standards, and protocols for their organizations.
  - Mechanisms for measuring accountability should be put in place for physicians and other clinical staff.

- It was noted that **leadership from the insurance companies (e.g., Fidelis Care) has not been willing to get involved with the initiative to date** – this group could cause a significant barrier in the future if they are not properly engaged.

- **Trust will need to be built across partnering organizations over time.**
  - Partners are concerned about the right leaders having a voice in directing programs and decisions, including geographical coverage, physicians, and other community partners outside of the major hospitals.
  - Smaller entities believe they are focused on being nimble, and are concerned with some of the rigor and process being put in place from a governance standpoint that may become tedious and hamper their way of functioning.
  - Governance leadership has asked that partners “don’t kick each other under the table” but instead “put it out on the table” as various entities work to integrate.

Note: Interview findings and observations are derived from the key stakeholder interviews conducted and may or may not be substantiated with further data analysis or research

Executive Leadership Interview Detailed Findings by Dimension

Vision / Mission / Strategy & Goal Alignment

Leadership

Workforce Management

Culture

Organization Agility

- Leaders note that **"care teams" need to be utilized more frequently and more effectively**.
  - Some physicians are facing challenges with effectively delegating work to nurses and other clinicians. Some only feel comfortable with this delegation if they have established personal relationships with the clinicians.
  - There is an opportunity to involve Nurse Practitioners more heavily in discharge planning.
  - Utilizing hospitalists and care managers effectively can lead to better standardization of care and better discharge planning. Physicians need to leverage mid-level providers.
- There is believed to be a **disconnect between clinical education and practice**.
  - Historically, the culture of Academic Medical Center is such that the teaching comes first and the patient care comes second. This culture could cause challenges with the coordination.
  - It is believed that medical schools are not teaching health care professionals the latest coordinated care models that need to practiced in the field today (e.g., the definition of care transitions).
  - Healthcare professionals need to be educated on how to refer to the community (e.g., ER doctors should be given a list of community resources in case there are Social Workers of Case Management staff unavailable at the time of the discharge).
- The healthcare industry has faced a disproportionately high degree of change in recent years and there is a degree of **"change fatigue" in the workforce**.
- It was noted that many **PCPs are unwilling to take Medicaid patients or patients with histories of behavioral health**. There are no consequences for this behavior.
- It has been a **challenge to "find the right people with right skill mix** and put them in the right place."
- It was suggested that **adding more mid-level providers to primary care clinics** could help with some of their capacity issues, and prevent patients from resorting to the ER. At the same time, **generational differences mean newer nurses are looking for additional balance** from the profession.
- Workforce data for the extended community suggests a **need for additional social workers, home health aides, and dental assistants**, all contributing skillsets to care management.

Note: Interview findings and observations are derived from the key stakeholder interviews conducted and may or may not be substantiated with further data analysis or research

Executive Leadership Interview Detailed Findings by Dimension

Vision / Mission / Strategy & Goal Alignment

Leadership

Workforce Management

Culture

Organization Agility

- Overall, it was noted that Upstate is **slow to change and to make decisions.**
- Leaders emphasize that an overall **paradigm shift is needed from a physician-centered model to a patient-centered model**. Physicians should no longer be "cherry picking patients", or allowing reimbursement to drive all of their decisions.
- There are still practices of "**relationship-based" information sharing** in which clinical staff only share patient information with the other staff whom they know.
  - This behavior can be a barrier to acting in a coordinated fashion.
  - "Limitations to enhance coordination of care are more philosophical than technical."
- Past behaviors around **engaging home care** could cause challenges with care coordination.
  - Home care needs to get involved earlier in the process to prevent the need for services later. St. Camillus is a model example for involving home care in the discharge process.
  - Physicians need to be willing to refer patients to use home-based services (e.g., Physicians are referring patients to Infusion Centers when this care could be provided in the home setting).
  - There is often bias against the idea of Home Health because there is said to be an inadequate amount of reimbursements available for them to be effective.
  - There is a need for more home health aides, particularly in rural areas.
- **Communication is a key part of coordinating care and needs to be enhanced in a variety of different ways**.
  - Additional communication is needed around the resources available in the community so patients will utilize these resources as a first defense in place of coming straight to the ER.
  - Overall communication between different providers (PCPs, SNFs, LTACs, etc.) is not sufficient or effective, partially due to technology constraints, partially due to culture.
  - Physicians need to start communicating better with hospitals and vice versa.
- There is a large population of refugees in Central New York (especially Utica) from a variety of countries and it can be a **challenge to meet all of the language and cultural needs of diverse populations**.
  - Translator fees can cost more than the reimbursement for the entire visit.

Note: Interview findings and observations are derived from the key stakeholder interviews conducted and may or may not be substantiated with further data analysis or research

Executive Leadership Interview Detailed Findings by Dimension

Vision / Mission / Strategy & Goal Alignment

Leadership

Workforce Management

Culture

Organization Agility

- Leadership agree that there is a **lack of capacity in ambulatory clinics throughout Central New York**, especially in the rural areas. It was suggested that Telemedicine and Mobile Crisis Units could provide a partial solution.
- There is also a **lack of certain services, such as dental**, **and medical specialties** in the community.
- **The care transitions between pediatric care and adult care have proved to be especially difficult to orchestrate**. Joselin diabetes has been a successful example.
- Leaders note that **regulatory issues can be prohibitive to comprehensive care delivery** (e.g., prior authorizations, scope of practice, DVS, etc.) and can create “reimbursement siloes”.
- There seems to be a **lack of a standard discharge process**, which poses a significant barrier to successful coordination.
  - Hospitals historically have not contacted Federally Qualified Health Centers (FQHCs) before discharging an established patient in order to coordinate post-discharge care.
  - It is believed that patients with needs that can be met through community resources are still not being discharged from inpatient services.
  - The “cross-continuum collaboration team” is working to set-up standardized discharge processes and handoffs, which could be an enabler to the overall care transitions initiative.
  - Follow-up after the discharge is becoming increasingly important to avoid readmission.
- **Technology was cited often as a barrier to integrated care**. Technology will need to improve to be able to meet the data management needs that DSRIP will require.
  - There are different EMR technologies used across the PPS, and only some of the physician practices have EMR.
  - “RHIO is not an elegant way to get information.”
  - EMR output is not discrete and concise – it contains so much information that it is difficult to use.
  - The Case Management system is separate from the main EMR, which creates difficulties in painting the full picture of the patient’s history.

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Organizational & Cultural Change Management Recommendations

Vision / Mission / Strategy & Goal Alignment

- **Align around a clear definition of care coordination and associated roles** (care managers, care coordinators, etc.) for the PPS, to leverage consistently in go forward planning and communications.
- **Clearly articulate the transformation strategy** to the organization, including an initial set of compelling strategic milestones associated with the projects.
- **Develop and execute a stakeholder-based comprehensive communications plan.**

Leadership

- **Agree to desired leadership behaviors** and adapt specific methods and tools to encourage demonstration of accountability, teaming, and comfort entering into conflict. Implement methods and measure effectiveness.
- **Drive change management efforts from the top down**, demonstrating leadership buy-in and alignment.
- **Define a decision model** and gain alignment on accountabilities, roles, and responsibilities across the various community partners involved.

Workforce Management

- **Define the skills and competencies needed for success with the transitions of care coordination initiative**, establish clear expectations for how roles may change, assess employees for these skills and develop recruitment plans focused around these skills.
- **Determine the training needs by stakeholder group** (e.g., PCPs, nurses), and develop training to meet these needs.

Culture

- **Assess current incentives in place for PCPs** and determine how they can be adjusted to reinforce collaborative behaviors and patient-centered care.
- **Build a communications network** that enables information sharing between members of the PPS.
- **Ensure stakeholder-based communications plan accounts for local needs** of patients, including language interpretation and modes of communication that resonate with the community.

Organization Agility

- **Define a standard discharge process and disseminate the standard throughout the PPS**; ensure that performance management is tied to compliance with discharge processes.
- **Assess the effectiveness of various capacity solutions**: Telemedicine, Mobile Crisis Units, etc. to determine where to invest for the future.

Note: Interview findings and observations are derived from the key stakeholder interviews conducted and may or may not be substantiated with further data analysis or research

Variations exist in the demand for physician services across the six counties

The table below estimates the number of providers required to meet the demand for services across the six counties based on the demographics in the area.

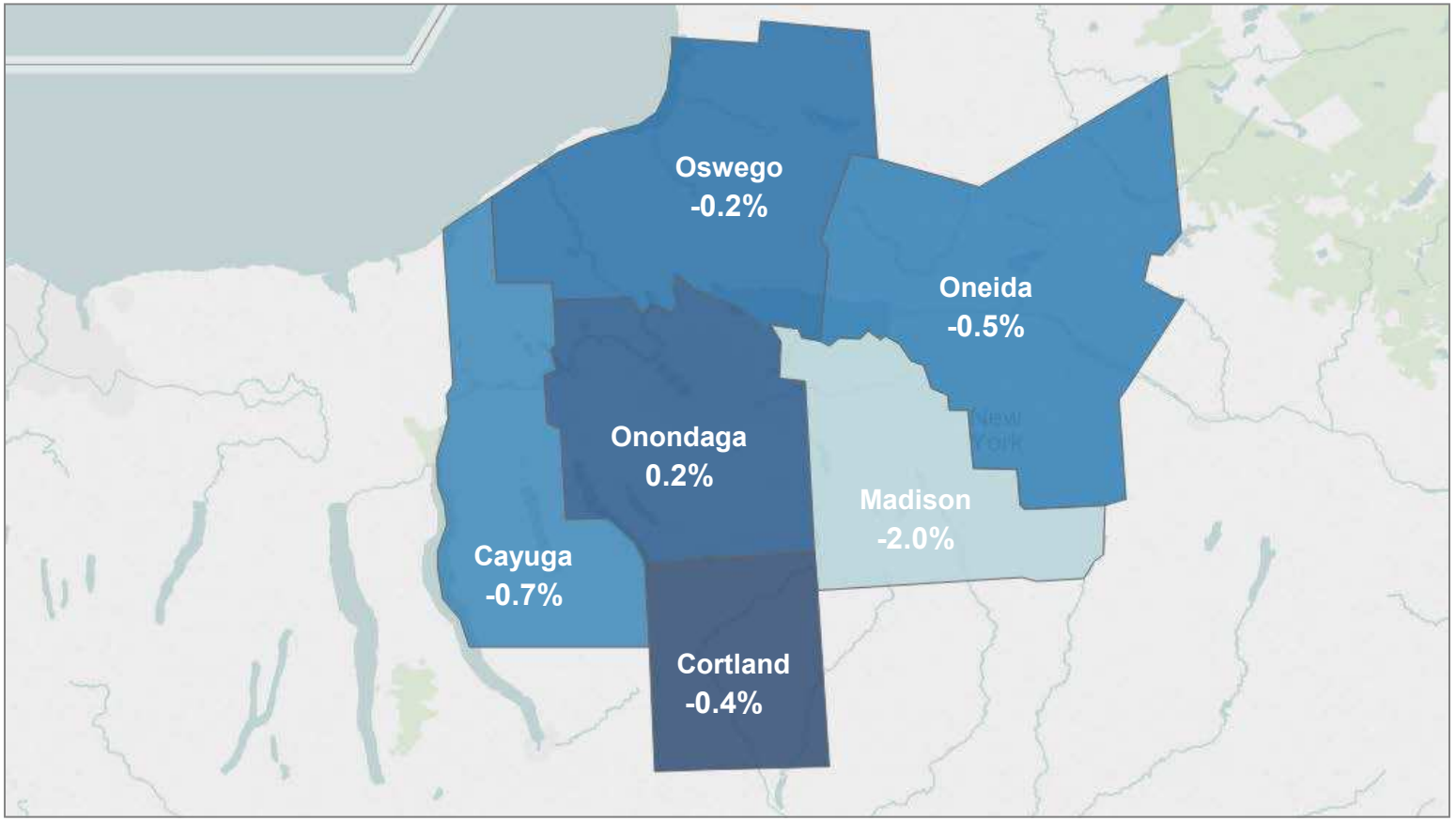
		CAYUGA	CORTLAND	MADISON	ONEIDA	ONONDAGA	OSWEGO
Primary Care	Family/General Practice	33	20	32	101	199	53
	Internal Medicine	43	24	40	128	246	64
	Pediatrics	20	15	20	61	126	34
Medical Specialist	Allergy/Immunology	1	1	1	3	7	2
	Cardiology	7	4	7	22	40	10
	Dermatology	4	2	3	11	21	6
	Emergency Medicine	11	7	11	34	68	18
	Endocrinology	1	1	1	3	5	1
	ENT	3	2	3	10	20	5
	Gastroenterology	4	2	4	12	22	6
	Hematology / Oncology	3	1	2	8	14	4
	Infectious Disease	2	1	1	5	9	2
	Nephrology	2	1	2	7	13	4
	Neurology	4	3	4	14	26	7
	OB / GYN	12	8	12	36	74	20
	Ophthalmology	7	3	6	20	37	10
	Orthopedics	8	5	8	24	47	12
	Other Medicine	2	1	2	6	12	3
	Other Specialty	3	2	3	10	19	5
	Physical Medicine and Rehab	3	2	3	9	18	5
	Psychiatry	14	9	14	44	89	24
	Pulmonary Disease	3	2	3	10	19	5
	Radiology	12	8	12	37	74	20
	Rheumatology	1	1	1	4	8	2
	Urology	4	2	3	11	21	5
Surgical Specialist	Cardiac/Thoracic Surgery	2	1	2	6	12	3
	General Surgery	10	6	9	30	58	15
	Neurosurgery	2	1	2	5	11	3
	Other Surgery	1	1	1	3	7	2
	Plastic Surgery	2	1	2	6	13	3
	Anesthesiology	13	8	12	39	78	21
	Pathology	5	3	5	15	29	8

There is a high demand for primary care services in all the counties, but Oneida and Onondaga have a higher demand for medical specialists and surgical specialists

Source: High Value Networking Tool (HVNT). Converge Health. Truven Market Expert Provider Analyst

The majority of the six county region is expected to see a slight decline in population over the next 5 years

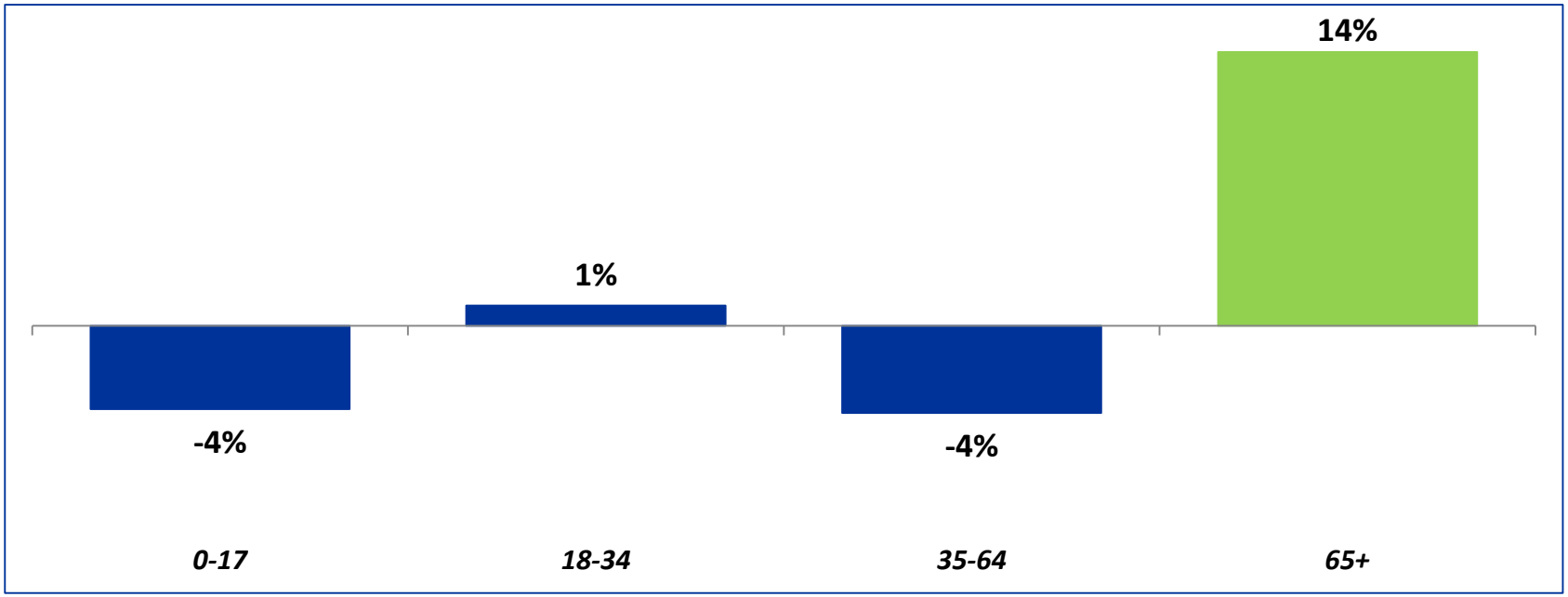
Population 5-Year Annual Growth Rates by County



Source: Truven Health Analytics

While overall population growth in the region is expected to be stagnant, the population is aging

Estimated 5 Year Population Growth Rate
6 County Region, CAGR by Age Group



The aging population will contribute to an increase in dual eligibles. This population must be effectively managed, as they generate higher utilization and spend

Source: Truven Health Analytics

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There are common themes in the qualitative assessment of the pervasive health issues that exist in each community

Summary of Themes

Cayuga	Cortland	Madison	Oneida	Onondaga	Oswego
• **Obesity** • **Alcohol abuse** • **Poor mental health** • Poor nutrition • Lack of physical activity • Injury and motor vehicle mortality	• **Obesity** • **Smoking among pregnant women** • Lung cancer • Hepatitis C • Lack of physical activity	• **Obesity** • **Substance abuse** • **Need for mental health professionals** • Poor access to care	• Shortage of providers • Lack of coordination of care • Underutilization of services	• **Obesity** • **Mental health** • Diabetes • Lack of physical activity • Access to care • Teen pregnancy and STDs	• **Obesity** • **Smoking** • **Mental health** • **Substance abuse** • Underutilization of services

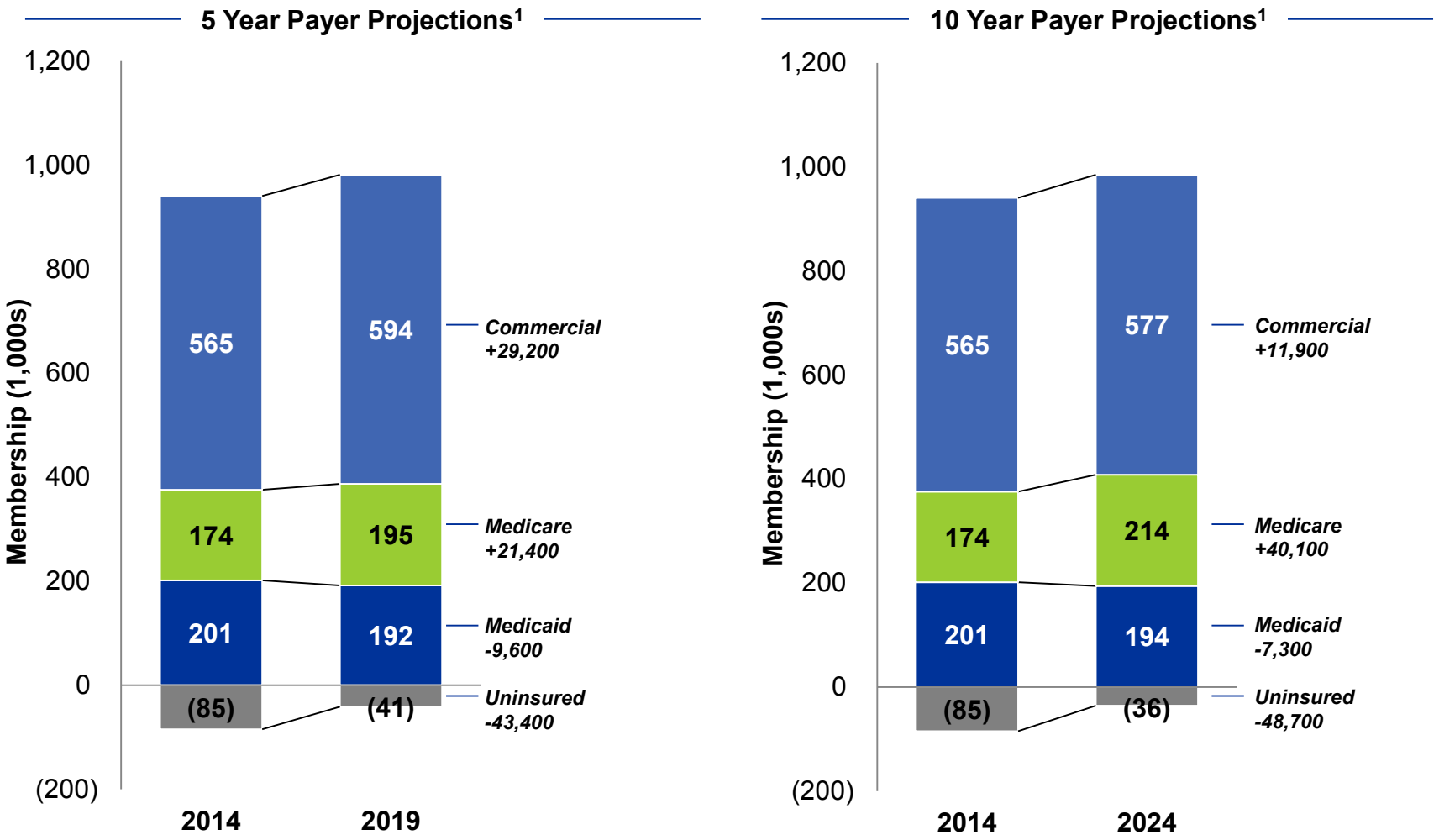
Obesity

Substance Abuse
Mental Health

Smoking

Sources: Community Health Assessment & Community Health Improvement Plan 2013 – 2017. Cayuga County Health Department. Nov. 2013.; Cortland Counts: An Assessment of Health and Well-Being in Cortland County. Seven Valleys Health Coalition, Inc. 2013.; Community Memorial Hospital Comprehensive Three-Year Community Service Plan. Community Memorial Hospital. Hamilton, New York. Nov. 2013.; Community Health Assessment 2013 – 2017. Oneida County Health Department. Nov. 2013.; 2013 Community Health Needs Assessment and 2014 – 2017 Community Benefits Implementation Plan. Crouse Hospital.; Community Service Plan 2014 – 2016. Oswego Hospital.; NOCHSI New Access Point Program.

A significant decrease in the number of uninsured and small decrease in Medicaid members is expected in the next 5 to 10 years



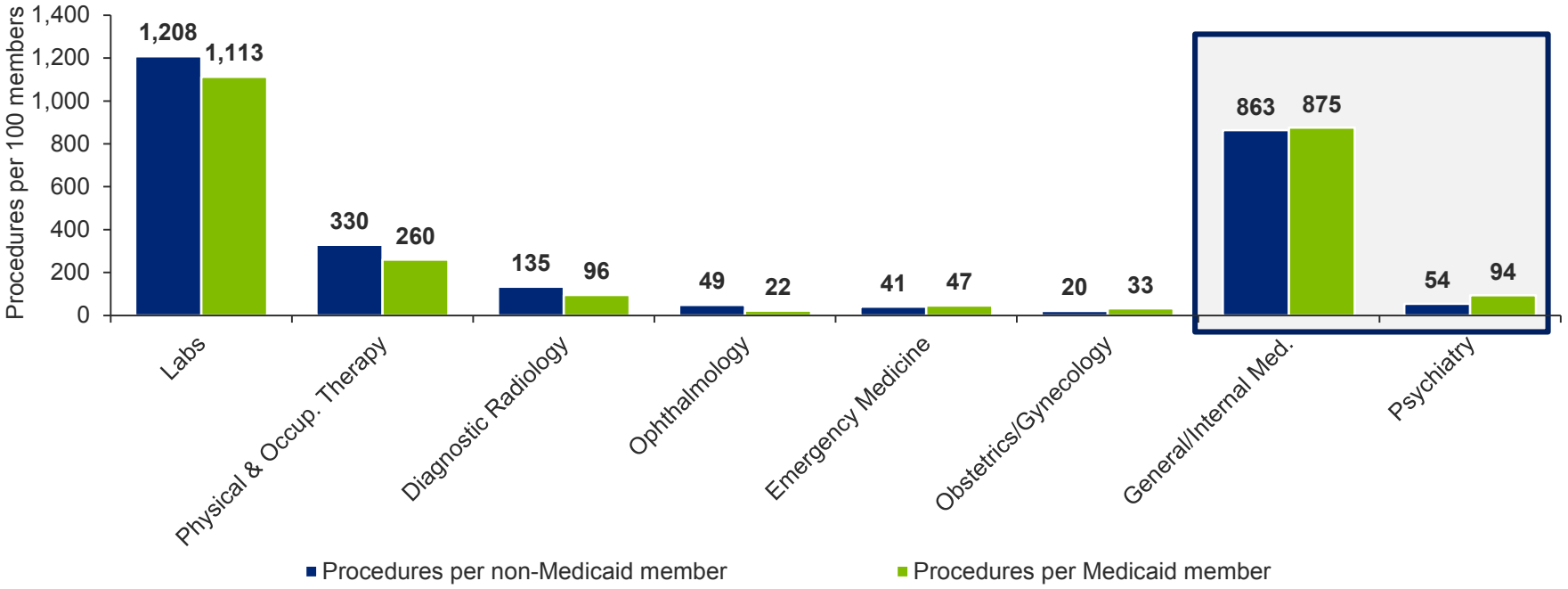
1. Includes payer membership estimates for Central NY counties including Cayuga, Cortland, Madison, Oneida, Onondaga, and Oswego

Source: Truven Health Analytics

Demand for different services vary across the six counties for Medicaid members vs. non-Medicaid members

Medicaid members are observed to have higher rates of usage for both primary care and psychiatry procedures versus the general population

Procedures per 100 members in Medicaid vs. non-Medicaid



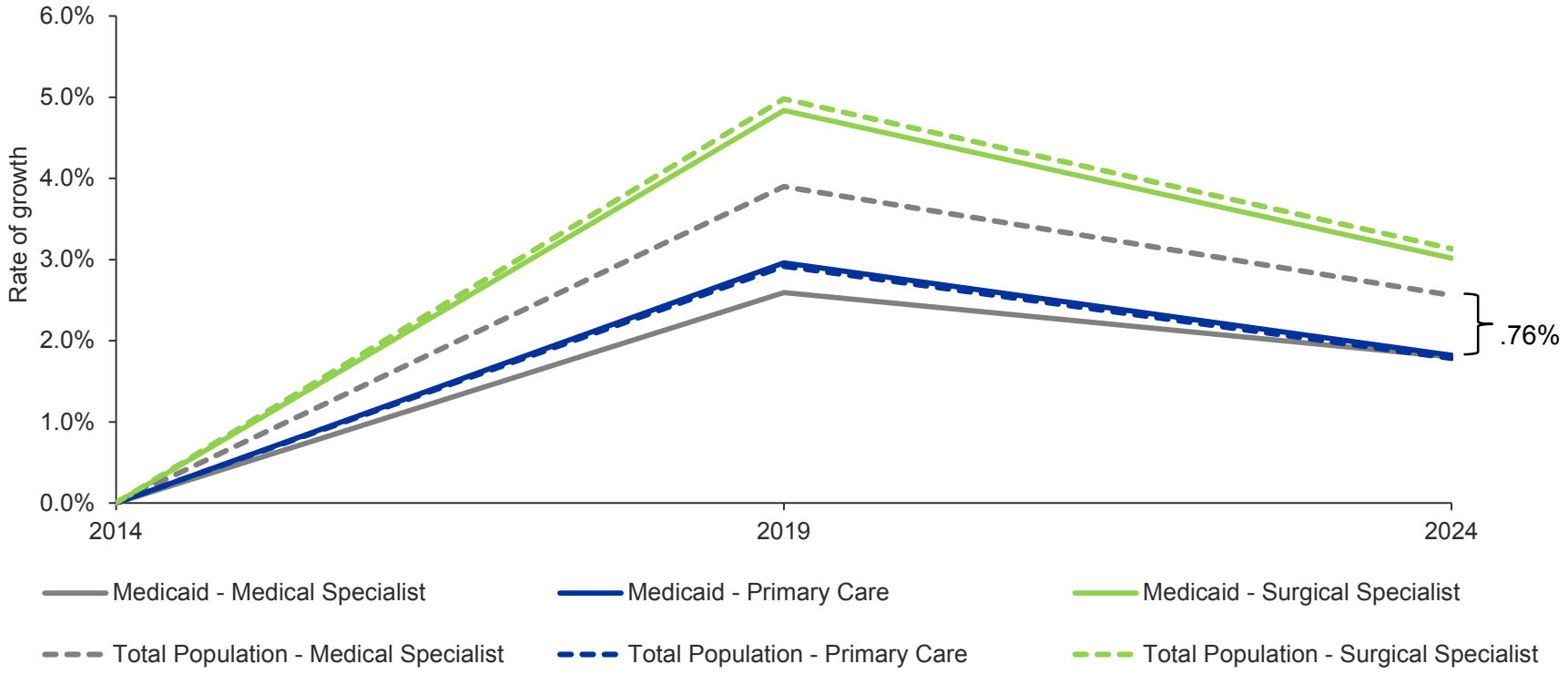
Variations exist in the demand for services for Medicaid and non-Medicaid members

Source: Truven Health Analytics

Projected growth in Medicaid procedures vs. general population

Projected Medicaid growth will rise among all three areas and then slowly decline in 2024, yet variations exist in the demand for medical specialists between Medicaid and the general population

Projected rate of growth in procedures between Medicaid and general population



Expected growth is similar between Medicaid and the general population with the exception of medical specialist procedures

Source: Truven Health Analytics

There is a greater supply of physicians in Oneida and Onondaga counties than in other counties

The table below shows the number of physicians per specialty across the six county region

		CAYUGA	CORTLAND	MADISON	ONEIDA	ONONDAGA	OSWEGO
Primary Care	Family/General Practice	16	16	28	102	211	33
	Internal Medicine	31	13	12	79	217	23
	Pediatrics	10	3	10	27	189	8
Medical Specialist	Allergy/Immunology	1	0	0	0	7	1
	Cardiology	2	1	1	20	61	0
	Dermatology	2	1	0	3	11	0
	Emergency Medicine	8	16	6	12	78	7
	Endocrinology	1	0	0	5	9	0
	ENT	0	3	1	8	30	2
	Gastroenterology	2	1	1	14	25	2
	Hematology / Oncology	1	1	1	4	15	1
	Infectious Disease	0	0	0	4	13	0
	Nephrology	0	0	0	5	22	0
	Neurology	3	0	2	9	39	1
	OB / GYN	8	4	6	29	102	6
	Ophthalmology	5	1	2	13	49	2
	Orthopedics	7	3	7	18	66	3
	Other Medicine	0	1	0	6	18	2
	Other Specialty	1	1	0	6	30	0
	Physical Medicine and Rehab	0	1	0	13	22	1
	Psychiatry	8	3	6	53	117	7
	Pulmonary Disease	0	0	0	9	21	1
	Radiology	4	3	3	33	119	4
	Rheumatology	0	0	0	2	13	1
	Urology	3	2	3	7	24	1
Surgical Specialist	Cardiac/Thoracic Surgery	0	0	0	5	25	0
	General Surgery	8	5	6	26	60	5
	Neurosurgery	0	0	0	6	17	0
	Other Surgery	0	0	0	0	9	0
	Plastic Surgery	0	0	0	4	15	0
	Anesthesiology	5	4	10	36	107	4
	Pathology	1	2	2	10	69	2

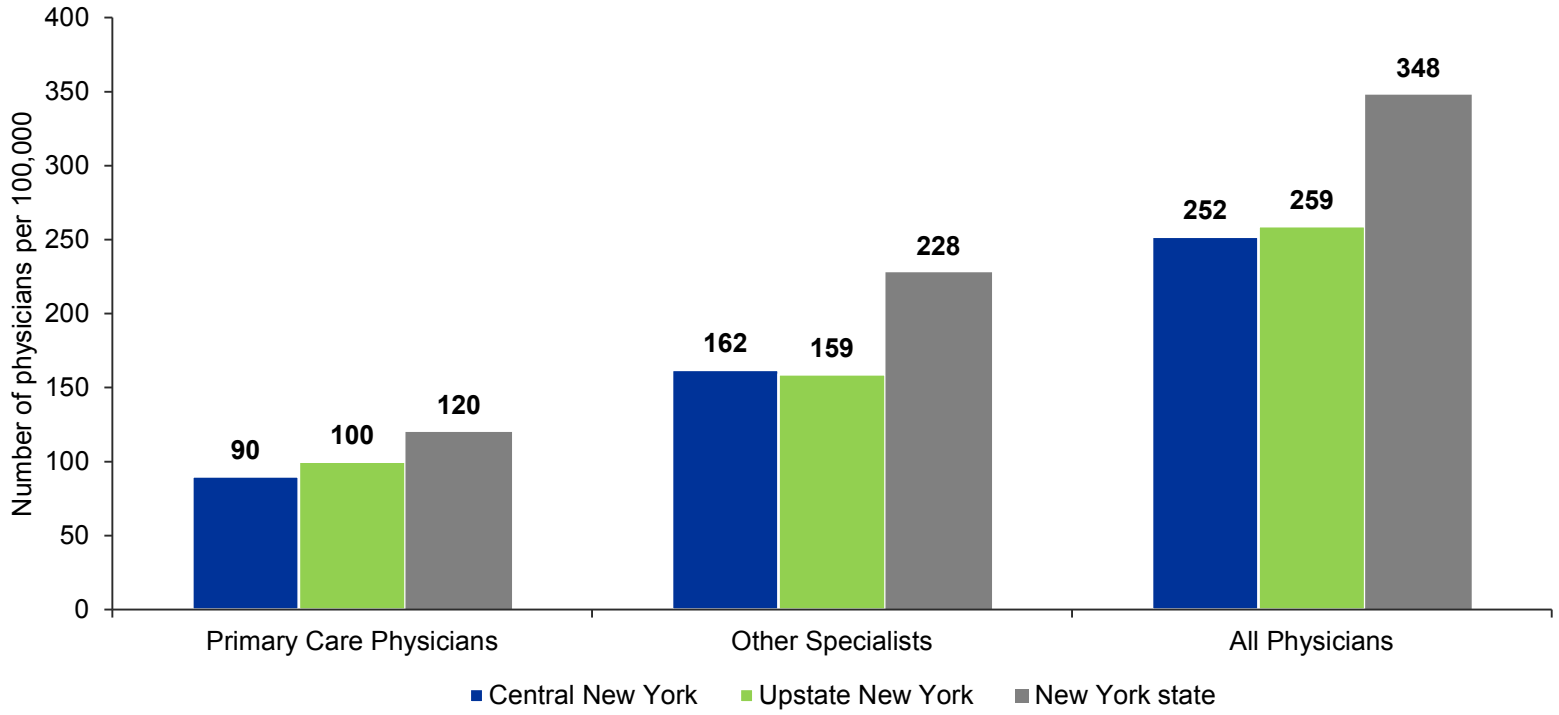
Stakeholder interviews indicated that the current supply of physicians in the region is inadequate to serve the needs of the population

Source: High Value Networking Tool (HVNT). Converge Health. Truven Market Expert Provider Analyst

Number of physicians per 100,000 in Central New York vs. New York state

The Central New York region has a lower density of physicians per 100,000 for both primary care and specialty practices compared to the rest of New York state

Number of primary care physicians and specialists in central New York vs. New York state



The number of physicians per 100,000 is lower for the Central New York region compared to the rest of the state.

Source: New York State Health Workforce Planning Guide. Center for Health Workforce Studies. University of Albany, School of Public Health.

The need for physicians is highest in primary care across all counties

The table below combines the analysis of supply and demand in the region to determine the degree of oversupply or undersupply of physician per service line

		CAYUGA	CORTLAND	MADISON	ONEIDA	ONONDAGA	OSWEGO
Primary Care	Family/General Practice	(17)	(5)	(4)	1	12	(20)
	Internal Medicine	(12)	(11)	(28)	(49)	(29)	(42)
	Pediatrics	(10)	(12)	(10)	(33)	63	(26)
Medical Specialist	Allergy/Immunology	0	(1)	(1)	(3)	0	(1)
	Cardiology	(5)	(3)	(6)	(2)	21	(10)
	Dermatology	(2)	(1)	(3)	(8)	(10)	(6)
	Emergency Medicine	(3)	8	(5)	(22)	10	(12)
	Endocrinology	0	(1)	(1)	2	4	(1)
	ENT	(3)	0	(2)	(2)	11	(3)
	Gastroenterology	(2)	(1)	(3)	2	2	(4)
	Hematology / Oncology	(2)	(1)	(1)	(4)	1	(3)
	Infectious Disease	(2)	(1)	(1)	(1)	4	(2)
	Nephrology	(2)	(1)	(2)	(2)	8	(4)
	Neurology	(1)	(3)	(2)	(5)	12	(6)
	OB / GYN	(4)	(4)	(6)	(8)	28	(14)
	Ophthalmology	(2)	(2)	(5)	(7)	12	(8)
	Orthopedics	(1)	(2)	(1)	(6)	19	(10)
	Other Medicine	(2)	0	(2)	0	6	(1)
	Other Specialty	(2)	(1)	(3)	(4)	11	(5)
	Physical Medicine and Rehab	(3)	(1)	(3)	4	4	(4)
	Psychiatry	(6)	(6)	(8)	9	28	(17)
	Pulmonary Disease	(3)	(2)	(3)	(1)	2	(4)
	Radiology	(8)	(5)	(9)	(4)	45	(16)
	Rheumatology	(1)	(1)	(1)	(2)	5	(1)
	Urology	(1)	0	0	(4)	3	(4)
Surgical Specialist	Cardiac/Thoracic Surgery	(2)	(1)	(2)	(2)	13	(3)
	General Surgery	(2)	(1)	(3)	(4)	1	(11)
	Neurosurgery	(2)	(1)	(2)	1	6	(3)
	Other Surgery	(1)	(1)	(1)	(3)	2	(2)
	Plastic Surgery	(2)	(1)	(2)	(2)	2	(3)
	Anesthesiology	(8)	(4)	(3)	(2)	29	(17)
	Pathology	(4)	(1)	(3)	(5)	40	(6)

(50) 50

A potential opportunity exists to leverage the oversupply of physicians in Onondaga County to meet the needs of other counties

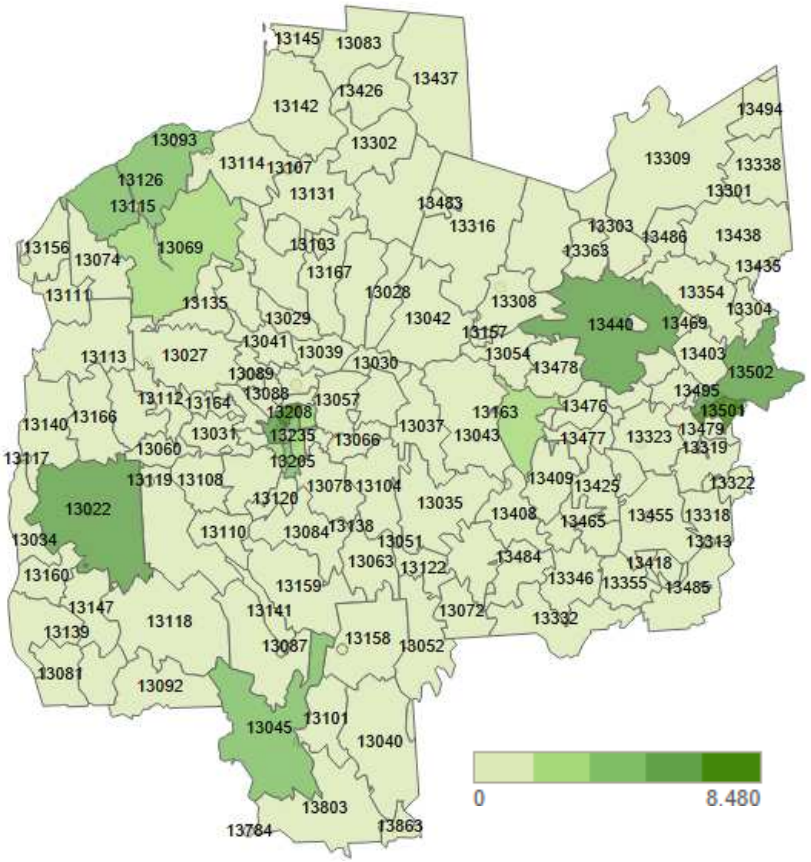
Source: High Value Networking Tool (HVNT). Converge Health. Truven Market Expert Provider Analyst

The degree of need in the region is influenced by the growth in Medicaid enrollment and the number of physicians accepting Medicaid

	Variables	Discussion	Implications	
Medicaid Growth	Medicaid enrollment rises	• If Medicaid enrollment continues to rise, the demand on physicians will also rise, shrinking supply	• Greater need of physicians and services	
	Medicaid enrollment shrinks	• If Medicaid enrollment shrinks, demand will decrease	• Need will decrease	
Physician Acceptance	Physicians accept more Medicaid patients	• If physicians accept more Medicaid patients, the supply will increase	• Need will be better met	
	Physicians accept less Medicaid patients	• If physicians accept less Medicaid patients, supply will shrink	• Need will increase and community health will decline	

Several geographic areas have a significantly higher rate of Potentially Preventable ER visits (PPV[1]) when compared to the rest of the region

Number of Medicaid PPVs by Zip Code



Top Ten PPV Zip Codes		
Zip Code	County	Number of PPVs
13501	Oneida	8480
13208	Onondaga	7040
13204	Onondaga	6399
13440	Oneida	6273
13021	Cayuga	5540
13502	Oneida	5207
13203	Onondaga	4954
13205	Onondaga	4679
13126	Oswego	4181
13045	Cortland	3541

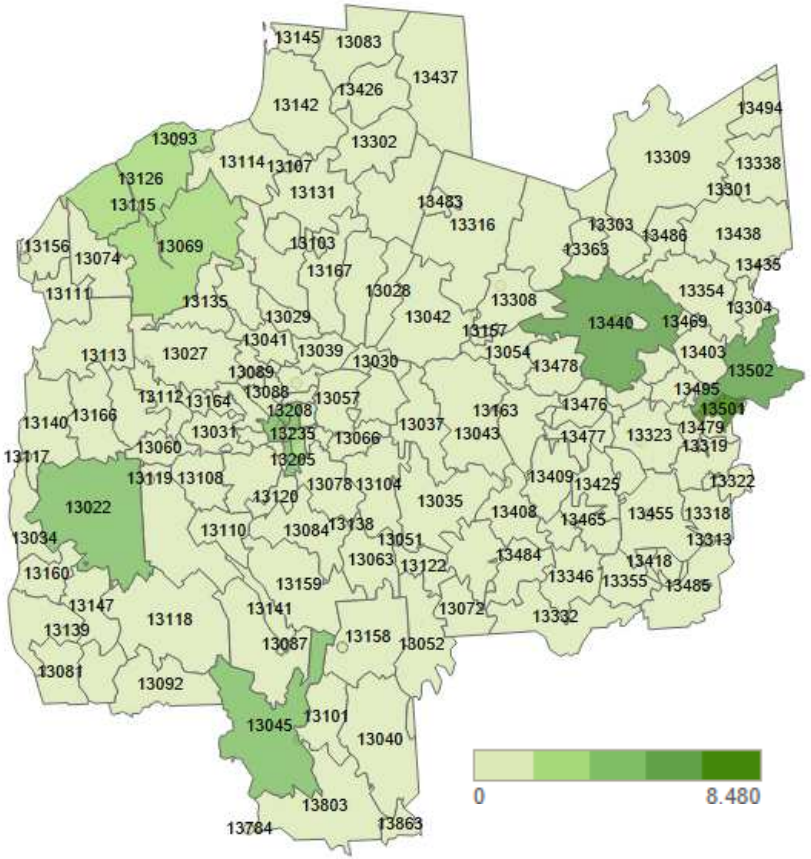
Note: Potentially Preventable Visits (PPV) is obtained from software created by 3M Health Information Systems for conditions that could otherwise be treated by a care provider in a non-emergency setting.

Greater access to primary care services can be bolstered in those areas with a high number of Potentially Preventable ER Visits reducing admissions

Source: Health Data NY Medicaid Potentially Preventable Emergency Visit (PPV) Rates by Patient County

Several geographic areas have a significantly higher rate of Preventable Quality Indicators (PQIs[1]) when compared to the rest of the region

Number of Medicaid PQIs by Zip Code



Top Ten PQI Zip Codes		
Zip Code	County	Number of PQIs
13501	Oneida	275
13502	Oneida	180
13440	Oneida	166
13045	Cortland	164
13204	Onondaga	149
13205	Onondaga	146
13021	Cayuga	131
13208	Onondaga	122
13203	Onondaga	118
13210	Onondaga	92

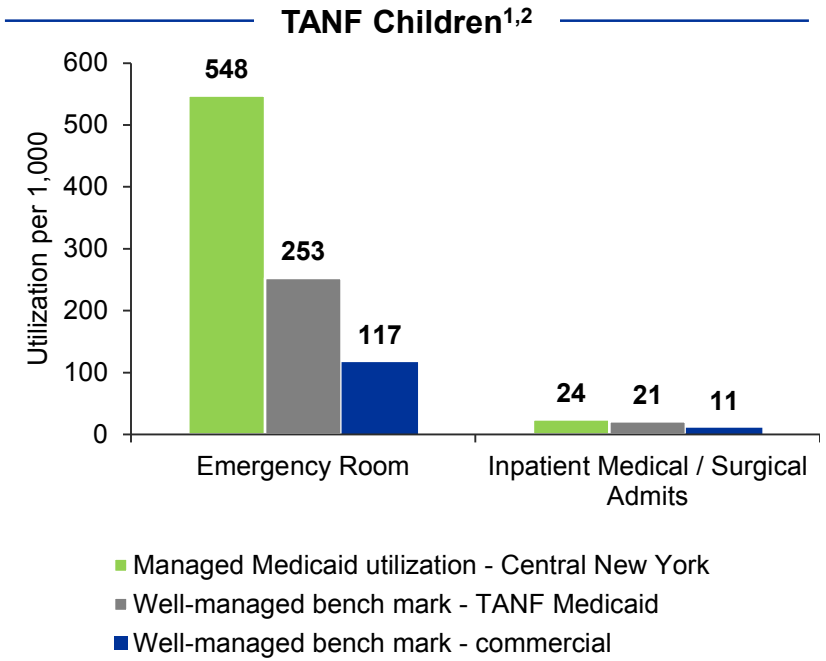
Note: The Prevention Quality Indicators (PQIs) are a set of measures for conditions for which good outpatient care could potentially prevent the need for hospitalization.

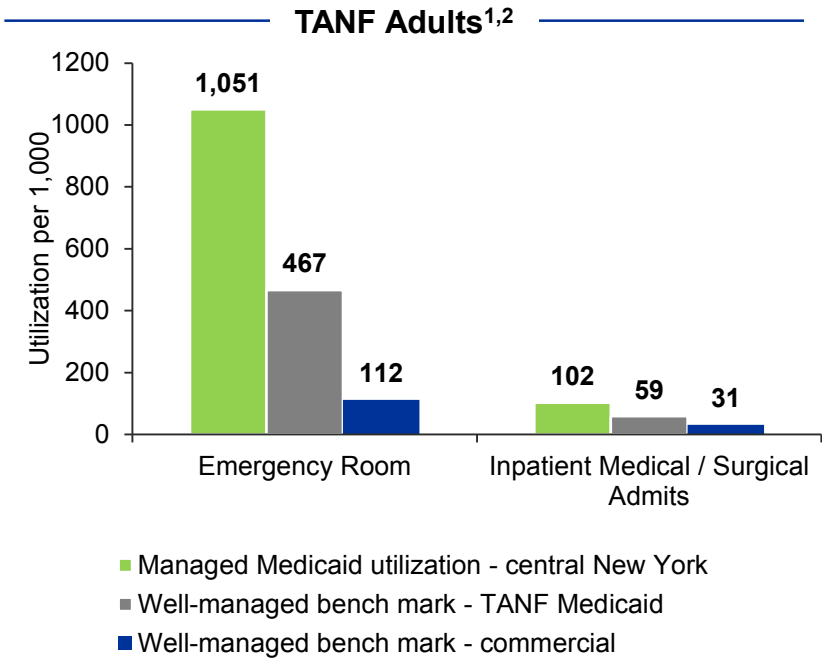
Care management resources and efforts should be prioritized in those areas with the highest rate of Preventable Quality Indicators

Source: Health Data NY Hospital Inpatient Prevention Quality Indicators (PQI) for Adult Discharges by County (SPARCS)

Medicaid managed care members in the region have higher utilization compared to benchmarks national Medicaid managed care

Compared to national Medicaid managed care benchmarks, the central New York region has higher rates of utilization





An opportunity exists to reduce utilization by improving care management among Medicaid members

Source: Milliman Memorandum. *Analysis of Central NY Managed Medicaid Utilization Experience.* Nov. 4, 2014

1. Medicaid utilization based on 2013 MMCOR data for central region

2. Benchmark utilization based on Milliman's 2014 Health Cost Guidelines for commercial population in the Central Region, adjusted for demographics & health management; & TANF HCGS July 1, 2008

Community resources can assist in meeting key goals

Various community organizations and initiatives exist in each of the counties that focus on the most pervasive health issues of each community

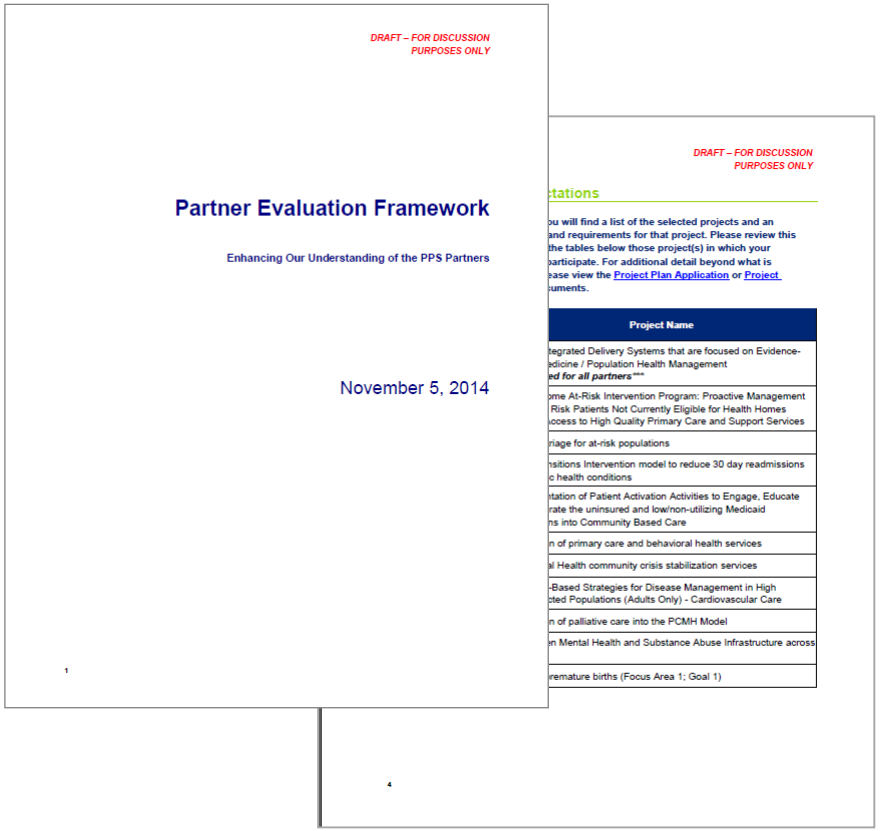
	Cayuga[1]	Cortland	Madison	Oneida	Onondaga	Oswego
Obesity	Creating Healthy Places to Live, Work, and Play Booker T. Washington Community Center Cato-Meridian Community Recreation Center	Eat Smart NY YMCA / YWCA Healthy NOW! Living Healthy Workshops	Community Action Partnership of Madison County ACR Health Cornell Cooperative Extension (Madison County)	Nutrition Outreach and Education Rome Hospital Nutrition Counseling St. Luke's Nutrition Counseling YMCA / YWCA Eat Smart NY	Creating Healthy Places to Live, Work, and Play Crouse Hospital Educational Seminars	Oswego AmeriCorps Program Fulton and Oswego YMCA 4-H Youth Development Program – Nutrition Education
Substance Abuse & Mental Health	2-1-1/Life Line Alcohol and Substance Abuse Services Prevention Network Auburn City Problem Solving Court C.H.A.D. (Confidential Help for Alcohol and Drugs)	Alcohol and Drug Clinic of Family Counseling Services of Cortland Seven Valleys Council on Alcoholism and Substance Abuse Cortland County Mental Health Clinic Think Again! Group	Insight House Chemical Dependency Services Madison County Council on Alcoholism and Substance Abuse	Catholic Charities Addictions Crisis Center Center for Addiction Recovery Community Recovery Center Mental Health Connections	Community Services and Mental Health Association of Onondaga Crouse Hospital Chemical Dependency Treatment Services Syracuse Behavioral Healthcare Syracuse Community Health Center	Chemical Dependency Program Conifer Park Alcohol and Drug Treatment Center Farnham Family Services Harbor Lights Chemical Dependency Services
Smoking	Tobacco Free Network of Central New York Smoker's Quit line	Nurse Direct Phone Counseling United Health Services Tobacco Cessation	Tri-County Quits	Tri-County Quits	Tobacco Control Program	Tobacco Free Network of Oswego County

Sources: Living in Cayuga County 2015. Human Service Coalition of Cayuga County. Oneida County Community Resources. Community Services Directory – Oswego. Herkimer and Oneida County Resources 2014. Created by the Neighborhood Center, Inc. Utica, NY. Cortland County Health Services. 2014 Community Service Directory – Oswego County. Healthy Madison County.

1. Not an inclusive list.

The Partner Evaluation Framework is designed to evaluate partner fit, contribution and requirements from Central New York Care Collaborative

The Partner Evaluation Framework survey was distributed to all providers who have indicated a desire to participate with CNYCC



- Distributed week of 11/10 to roughly 250 partners in order to facilitate the allocation of partners to each DSRIP initiative
- Survey consists of:
  - Partner overview information including key contacts, address and phone number
  - Number and type of providers, employees, and union status
  - Level of service provided to target population of Medicaid and uninsured
  - Description of DSRIP initiatives, objectives and requirements
  - Desired level of contribution to the initiatives
  - HIT/HIE sophistication and abilities
  - PCMH certification information
  - Medicaid waiver/program participation

Note: Select object to view entire partner survey

Two distinct analyses of the CNYCC partner organizations were conducted

FOR DISCUSSION PURPOSES ONLY
DRAFT

Partner List Breakdown 12/2/14

Provider Summary	
Organization	422
Physician/NP/PA	1252
Total Providers	1674

Project Scale Categories	Total	Safety Net Providers	VAP Pending Exceptions
Primary Care Physicians	526	153	N/A
Non-PCP Practitioners	631	135	N/A
Hospital	15	13	1
Behavioral Health	196	79	12
Substance Abuse	53	17	0
Skilled Nursing Facilities/Nursing Homes	41	30	2
Pharmacy	7	0	0
Community Based Organizations	17	13	6
Hospice	4	1	0
Health Home/Care Management	38	15	2
Clinics	40	32	1
All Other	106	21	18
Total	1674	509	42

- A complete list of partners was compiled and analyzed to determine the following:
  - MAPP Data provided:
    - Provider Name
    - NPI (for most)
    - MMIS (for some)
    - Contact (name and e-mail)
  - DOH Data:
    - Safety Net providers
- The partner surveys were also collected and analyzed:
  - Received 140 provider survey responses
  - Matched 71.1% of responses to providers (1191/1674)
  - Survey Data provided:
    - Providers committed to projects
    - PCMH level, # of practices

The Care Transitions team led the development of 3 project plans and provided secondary support for 1 project plan application

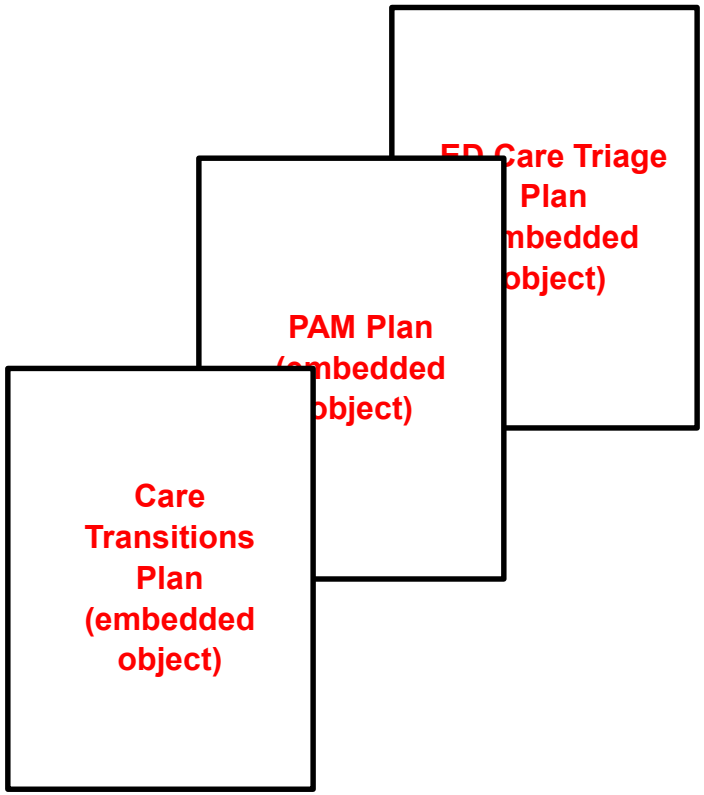
Project #	DSRIP Project Name	Project Owner	Lead Consultant Support	Secondary Consultant Support
2.a.i	**Create IDS**	Kari Burke	Randy Gordon (Deloitte)	Craig Stevens (JSI)
2.a.iii	**Increase Health Home for at risk patients**	Kristen Heath	Alec McKinney (JSI)	Danna Campbell (Deloitte)
2.b.iii	**ED Care Triage**	Enderli Frederiksen	Danna Campbell (Deloitte)	Craig Stevens (JSI)
2.b.iv	**Care Transitions**	Diane Nanno	Danna Campbell (Deloitte)	Angel (JSI), Amy (JSI)
2.d.i	**Implement PAM Pt Activation**	Diane Nanno	Danna Campbell (Deloitte)	Alec McKinney (JSI)
3.a.i	**Integrate PC & BH**	Susan Furtney	Sue Grantham (JSI)	Paula Zalucki (Deloitte) Craig Stevens (JSI)
3.a.ii	**BH Community Crisis Stabilization**	Kristen Heath	Sue Grantham (JSI)	Paula Zalucki (Deloitte) Craig Stevens (JSI)
3.b.i	**Evidence-based Strategies for DM for CV**	Cheryl Perry	Randy Gordon (Deloitte)	
3.g.i	**Integrate Palliative Care into PCMH**	Susan Furtney	Alec McKinney (JSI)	
4.a.iii	**Strengthen Mental Health & Substance Abuse**	Jeanette Angeloro	Sue Grantham (JSI)	Paula Zalucki (Deloitte) Craig Stevens (JSI)
4.d.i	**Pop Health Reduce Premature Births**	Cheryl Perry	Jocelyn Chu (JSI)	Susan Friedrich (JSI)

There were a number of deliverables developed to guide the completion of the project plan application

A project workplan, meeting content, and research findings were all used to guide the workgroups and drive the on-time development of a successful project plan application

The project plan application addressed the following topics .

Project approach
Alignment with the Community Needs Assessment
Target population
Assets and resources dedicated to the project
Challenges and mitigation strategies
Plan to coordinate with other PPS's
Scale of implementation
Speed of implementation
Financial infrastructure
Workforce implications
Regulatory implications



Note: Select objects above to view complete project plans

Interview Log and Detailed Minutes (Page 1 of 5)

Organization	Name	Role	Date	Minutes
Onondaga Case Management	Scott Ebner Deborah Donohue	Executive Director Former Executive Director	10/08/2014	
Upstate Children's Hospital	Leola Rogers	Associate Administrator	10/8/2014	
Upstate University Health System	Louise Pernisi	Director of Discharge Planning	10/8/2014	
Upstate University Health System	Dianne Nanno	Director of Care Transitions	10/8/2014	
Pulaski Health Center	Dan Dey	CEO	10/9/2014	

Interview Log and Detailed Minutes (Page 2 of 5)

Organization	Name	Role	Date	Minutes
Visiting Nurse Association of Central New York, Inc.	Kate Rolf	President and CEO	10/13/2014	
Upstate HomeCare	Greg LoPresti Lorie Ann Voight	Sr. VP and Chief Executive Officer VP, Clinical & Patient Financial Services	10/14/2014	
Upstate University Health System	Mark Buttiglieri	Director of Social Work	10/14/2014	
Finger Lakes Community Health	Jim Kennedy	Chief Compliance and Program Development Officer	10/15/2014	
Crouse Hospital	Joan Dadey	Administrative Supervisor	10/15/2014	

Interview Log and Detailed Minutes (Page 3 of 5)

Organization	Name	Role	Date	Minutes
Faxton St. Luke's Healthcare	Scott Perra Michael Trevisani, MD Pat Roach Cheryl Perry	CEO & President CMO CNO DSRIP Coordinator	10/16/2014	
Utica Community Health Center	Janine Carzo	CEO	10/16/2014	
Upstate Services Group	MaryPat Carhart	Vice President Clinical Service	10/16/14	
Upstate University Health System	Shawna Craigmille	DSRIP Project Manager	10/16/14	
FCMG	David Page	Managing Partner	10/21/14	

Interview Log and Detailed Minutes (Page 4 of 5)

Organization	Name	Role	Date	Minutes
Oswego Hospital	Renato Mandanas Bradley J. Chapman	Interim COO, Internal Med/Pulmonology Associate Administrator, Behavioral Health	10/21/14	
Sitrin Health Care Center	Christa Serafin	CEO	10/22/14	
Liberty Resources, Inc	Carl Coyle Marta Durkin Robert Feldman	CEO Vice President of Behavioral Healthcare Vice President of Clinic Services	10/22/14	
St. Camillus Home Care and St. Camillus RHCF	Aileen Balitz Chris Kearney	President & CEO VP of Rehab and Community Based Services	10/23/14	
Oneida Healthcare	Gene Morreale	CEO	10/23/14	

Interview Log and Detailed Minutes (Page 5 of 5)

Organization	Name	Role	Date	Minutes
Upstate Cerebal Palsy, Inc	Laura Eannace	Executive VP	10/23/14	
East Hill Family Medicine	Laura Eannance Gordon Dunham Tara Costello	Executive VP Associate VP VP of Behavioral Health Services	10/23/14	
Syracuse Community Health Center, Inc	Dr. Frankie Quarles Bernadette Griffith-Payne Daphene Johnson	Corporate Health Officer Director of Patient Services Project Manager, Recruitment/Retention Planning, Development, Grants Administrator	10/29/14	

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