



# Redesigning Medicaid Healthcare Delivery in the Finger Lakes Region

BRIDGING THE GAP BETWEEN COMMUNITY AND HEALTHCARE

IMPACT REPORT



*“We are not just  
**redesigning healthcare.**  
We have the opportunity  
to **redefine healthcare.**”*

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# A Message From Our CEO



This FLPPS Impact Report is a long time coming! Our original intent was to publish this report back in the summer of 2020, after DSRIP ended on March 31, 2020. We all remember that fateful month when all our collective priorities shifted to focus on battling the COVID-19 pandemic. We all partnered across our region and did what we had to do to ensure the health of our region. And so much has happened over the last 4 years since then! This report is intended to reflect on our past successes and update you on the last few years of our work. So much to say in so few pages, but we hope you take a few minutes to flip through the journey with us.

Implementing the New York State Department of Health's Delivery System Reform Incentive Payment (DSRIP) Program in the Finger Lakes region was an incredible 5-year journey that began in 2015. DSRIP's goal was to improve the design and delivery of healthcare for the Medicaid population; while reducing avoidable hospitalizations, improving population health, and lowering the cost of healthcare. And that we did! This effort could not have been successful without the work and support of the hundreds of partners across our 13-county region who participated in committees, task forces, workgroups, and project teams. And, I credit the incredible staff who worked so hard to make it happen, many of whom continue their journey as leaders across the community, and a few who are still with us today!

While DSRIP was successfully completed in 2020, our crucial work with partners continues.

FLPPS continues to advance our mission to improve the Medicaid healthcare delivery system through the collaborative relationships we have formed with partners and stakeholders across our region. This was evidenced in our work during the COVID-19 pandemic, joining forces with community partners to implement programming to educate, organize, and increase testing and vaccinations.

With our continued work in system transformation programming, care management through our health home, and innovative workforce initiatives, we are leveraging partnerships in our region's community to make some of the most innovative and transformative changes to our system.

As healthcare continues to evolve, more transformational opportunities are before us, and partners continue to look for expertise and support, the FLPPS team remains a vital and steadfast resource and partner to the community.

Our community is well positioned to continue to build a more resilient, flexible, and integrated delivery system that reduces racial disparities, promotes health equity, and supports the delivery of social care. With our partners and stakeholders, we see an incredible opportunity to further collaborate to make an even greater impact on health outcomes.

Over the years I have seen tremendous strides in community collaboration—organizations are not only working together, but they are also working more effectively, more efficiently, and are embracing change.

I am excited to continue this momentum. And I look forward to continuing our journey and achieving an even greater positive impact on health in our region.

*Carol Tegas*  
Chief Executive Officer

## WHO WE ARE

Finger Lakes Performing Provider System (FLPPS) is a 501(c)(3) not-for-profit organization established in 2014 to transform the healthcare delivery system by bridging the gap between community and healthcare. FLPPS is a partnership that includes a network of health and human services providers, including health systems, federally qualified health centers, nursing homes, behavioral health providers, and community-based organizations, across a 13-county region in Upstate New York.

## OUR MISSION

FLPPS was established with the mission of improving the healthcare delivery system for the Medicaid population.

## THE FLPPS PROMISE

We promise every interaction with our partners, and with each other, will be:



### COLLABORATIVE

Actively listen to individual contributions and remain open and approachable to participate on projects and teams.



### ADAPTIVE

Flexible and resilient to change; Stay open-minded and seek creative solutions.



### RESULTS-ORIENTED

Clearly define goals and commit to establish timelines; Remain organized and prepared to contribute to projects and initiatives.



### TRUSTED

Demonstrate integrity and respect all interactions; Actively community goals or intent; Be accountable for contributions within projects and teams.



### STRATEGIC

Forward-thinking and focused on aligning work to organizational vision.

*“Redesigning Medicaid healthcare delivery in the Finger Lakes region. Bridging the gap between community and healthcare.”*

# The Performing Provider System

## NEW YORK STATE DELIVERY SYSTEM REFORM INCENTIVE PAYMENT PROGRAM

In 2014, New York State invested \$8 billion in federal funding for the New York State Delivery System Reform Incentive Payment (DSRIP) Program, a New York State Medicaid Section 1115 demonstration.

Its purpose was to fundamentally restructure the healthcare delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25% over 5 years.

FLPPS was 1 of 25 regional Performing Provider Systems (PPS) that implemented the DSRIP program.

Each PPS was comprised of health and human services providers, or partners, who worked together

to implement specific projects supporting Medicaid members and the uninsured.

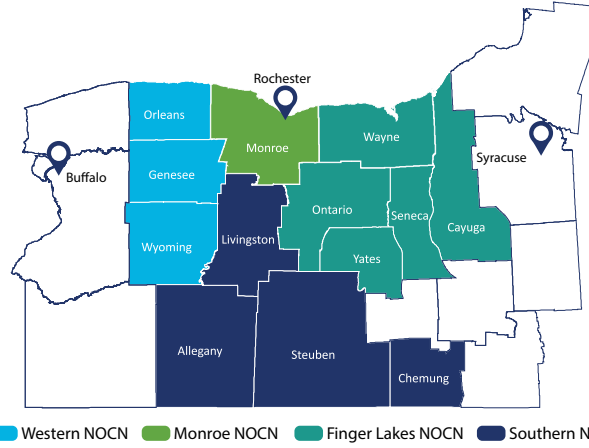
The FLPPS 13-county region covered more than 10,000 square miles, making it the largest and most geographically diverse PPS, with both urban and rural areas.

To effectively improve care delivery, we divided our 13-county region into 5 sub-regions, or Naturally Occurring Care Networks (NOCN). Each NOCN represented the full continuum of care and was led by a workgroup of healthcare and community-based leadership. This NOCN structure allowed FLPPS to develop a process for these individual organizations to come together and understand the value of an integrated delivery system for patients in their region.

Our governing committees—Board of Directors, Clinical Quality Committee, and Finance Committee—comprised of leaders from healthcare systems, federally qualified health centers, human and social services agencies, and government entities, would oversee the actions of FLPPS and provide guidance on ensuring we were meeting the goals of NYS.

Before DSRIP, many partner organizations operated in their silo and did not have the tools or processes to enable an integrated network approach to care delivery.

FLPPS worked with partners across our 13-county region to implement 11 innovative DSRIP projects designed for system transformation, clinical management, and population health.



Collectively, there were over 125 individual project milestones. Our timeline/launch projections for the speed at which we would implement and the scale of that implementation were incredibly aggressive and required a solid implementation plan that spanned the entire FLPPS geography.

FLPPS supported NOCNs in performing a root cause analysis to identify the cause of poorly performing outcomes supported implementing projects to address needs in those areas.

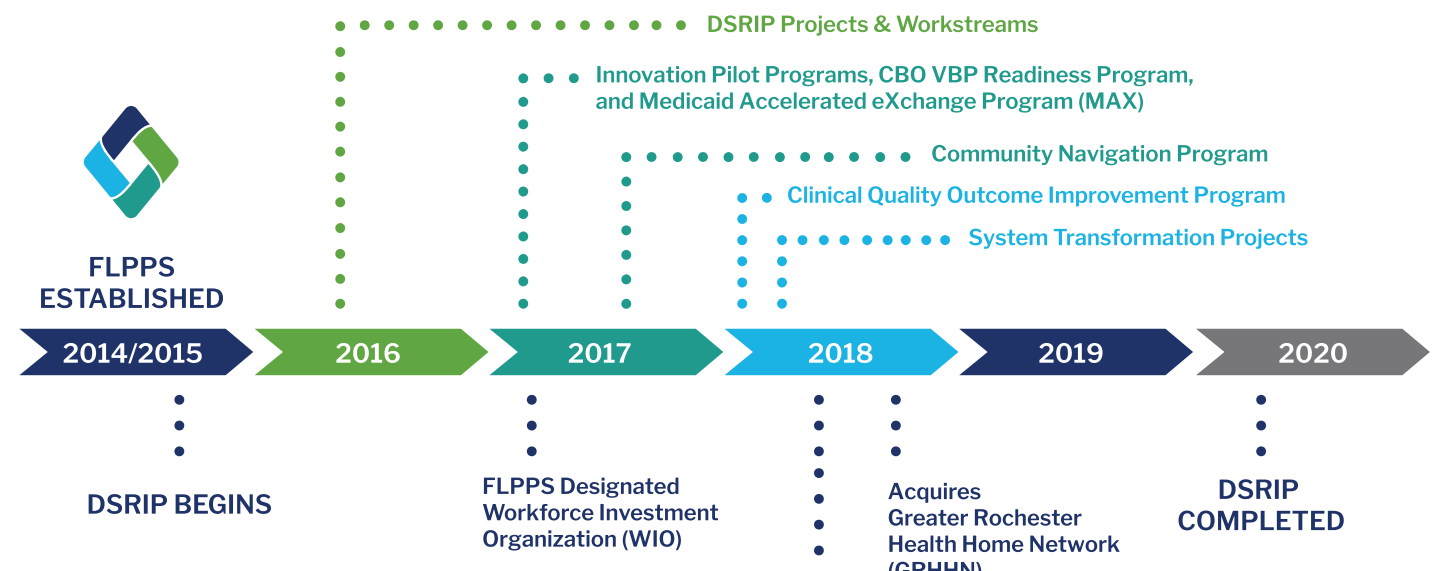
In addition, we implemented transformational work streams across our region related to workforce, housing, transportation, information technology, and cultural competency and health literacy.

These work streams were integral to supporting the infrastructure and change management necessary to sustain project best practices for:

- Creating an Integrated Delivery System
- Emergency Department Care Triage
- Care Transitions
- Transitional Supporting Housing
- Community Navigation and Patient Activation
- Behavioral Health and Primary Care Services Integration
- Behavioral Health Community Crisis Stabilization
- Behavioral Interventions Paradigm in Nursing Homes
- Maternal and Child Health
- Strengthen Mental Health and Substance Abuse Infrastructure
- Increase Access to Chronic Disease Prevention and Care

In 2015, FLPPS began developing our Cultural Competency/Health Literacy (CC/HL) Strategy, regarded as one of the top strategies to support the work of the DSRIP projects. In collaboration with Coordinated Care Services, Inc. (CCSI), we worked with the leaders and employees of more than 80 healthcare and nonprofit organizations across 9 counties. These organizations implemented strategies and activities to support health equity and improved health outcomes among the populations served. The work started by FLPPS, with support from CCSI, has been sustained in the policies, procedures, and activities that many of the organizations continue to practice today.

*“DSRIP allowed us to collaborate on a new level and think in a different way about how we can **develop with our patients a system that better supports our patients.** We did this with resounded success.”*



**REGIONAL IMPACT**  
**232,000**  
**PATIENTS ENGAGED**

Over the course of the DSRIP program, our partnership network improved performance in nearly 40 clinical outcome measures across the region, with significant achievements in several domains, including **behavioral health outcomes, long-term care, patient satisfaction, and maternity and children’s measures.**

Understanding that population health improvement requires cohesive participation by all partners, we focused on a region-wide approach to clinical outcome improvement.

Mid-DSRIP, we developed a strategy and implementation plan that would improve health outcomes quickly and significantly, via activities performed that would supplement the ongoing DSRIP projects.

Our Clinical Quality Committee (CQC) collectively examined specific characteristics of each clinical outcome metric and categorized the metrics into various categories for targeted improvement activities.

The CQC led an innovative program referred to as a “Sprint” to improve performance quickly, given there was only 3 months remaining in the fourth year of DSRIP.

**91%**  
**OF THE SPRINT**  
**IMPROVEMENT TARGETS**  
 were met or exceeded

We then initiated a “Jog” at the beginning of the final year of DSRIP and engaged additional partners, including community-based behavioral health organization networks and health homes, as these provider types would be critical in accomplishing improvement in behavioral health outcome metrics.

**95%**  
**OF THE JOG**  
**IMPROVEMENT TARGETS**  
 were met or exceeded

*“It is through each **partner organization** and stakeholder, as change agents, that **system transformation** will become a reality.”*

The NYS Medicaid Accelerated eXchange (MAX) program redesigned the way healthcare is delivered to a specific patient population—inpatient high utilizers—by utilizing a rapid cycle continuous improvement methodology.

The MAX program supported the goal of transforming healthcare by strengthening care collaborations and getting patients the right care at the right time.

By understanding the drivers of high utilization, patients are directed to appropriate community providers and resources while promoting the more efficient use of hospitals for emergent and acute-level services.

FLPPS facilitated and led 4 action teams over 2 years partnering with Arnot Health and UR Medicine.

FLPPS also facilitated a mini-MAX series with Jones Hospital in 2018, which established a structure for the hospital and community-based organizations to coordinate care and address social determinants of health for identified high utilizers.



Noyes Hospital MAX Project  
 Pilots Improving Health Care  
 Greater Rochester Quality Council’s  
 Performance Excellence Awards

**THE IMPACT ON INPATIENT UTILIZATION**

**58%**  
**REDUCTION**  
 Arnot Ogden Medical Center – Arnot Health  
 February 2017 – May 2017

**86%**  
**REDUCTION**  
 St. Joseph’s Behavioral Health Unit – Arnot Health  
 September 2017 – February 2018

**75%**  
**REDUCTION**  
 Geneva General Hospital – Finger Lakes Health-UR Medicine  
 November 2017 – March 2018

**89%**  
**REDUCTION**  
 Noyes Hospital – UR Medicine  
 July 2018 – February 2019

# SYSTEM TRANSFORMATION PROJECTS

# SYSTEM TRANSFORMATION COMMUNITY PARTNERS

As DSRIP work wound down, FLPPS shifted its focus to **community-based providers**. The System Transformation Projects shared a common goal—to continue transforming our healthcare system for the Medicaid population by incorporating community-based care to improve health outcomes.

FLPPS managed nearly 90 projects with community-based providers focused on integrating community with healthcare.

## MATERNAL AND CHILD HEALTH



2 Partners



5 Projects

Providing obstetric and pediatric care management services and doula services through the Black Doula Collaborative.

## SOCIAL DETERMINANTS OF HEALTH



25 Partners



30 Projects

Linkage and coordination of clinical and social care by Community Health Workers.  
 Providing rides to appointments.  
 Enhanced recovery support for individuals transitioning to permanent housing.  
 Providing healthy food and nutrition education programming.

## CARE MANAGEMENT



22 Partners



28 Projects

Enhancing health home care management activities to engage patients in care.  
 Integration of clinical and community-based resources to provide person-centered to individuals with intellectual and developmental disabilities.  
 Increasing capacity for care coordination activities.  
 Enhancing medication management and coordination.

## BEHAVIORAL HEALTH



22 Partners



26 Projects

Mental health and substance use disorder services.  
 Holistic health and wellness education.  
 Certified Peer Advocates using their lived experiences to engage with and support individuals needing care.

## WORKFORCE



18 Partners



33 Projects

In-person or e-learning training to support new employees in the onboarding process or the retraining of employees in connection with a new program or service.

## TELEHEALTH



3 Partners



3 Projects

Connecting patients to healthcare services through telemedicine.



Blossom Road Medicine, PLLC  
 Burce W. Mackellar, MD, PC  
 CareFirst Inc.  
 Dale L. Deahn, MD, PC  
 Livingston Wyoming Chapter,  
 NYSARC, Inc.

Mid-Erie Mental Health Services  
 Mohamad-Zahi Kassas, MD  
 Pembroke Family Medicine  
 Samaritan Women Inc.

# \$28.7M

## INVESTED

to continue to transform healthcare delivery with community-based integration

Several critical success factors led to this achievement, including the establishment of a central team comprised of experienced healthcare professionals, community-based staff, and subject matter experts who assembled the partnership network and drove network performance to deliver on the goals of the DSRIP program.

In addition, there was a small group of partners, or “Early Adopters”, who had the ability and capacity to engage individuals in our projects and paved the

way for the program’s success. These partners assisted in establishing and refining workflows that led to project implementation across our network.

Throughout the DSRIP program, our partnership network improved performance in nearly 40 clinical outcome measures across our region, with significant achievements in domains including behavioral health, maternal and child health, and care management.

**Creating an Integrated Delivery System**

**OUTCOME**

122 partners connected to the Rochester Regional Health Information Organization  
937 Level 3 Primary Care Medical Home Certified Providers

**Emergency Department Care Triage**

**OUTCOME**

17 hospitals and 55,952 patients engaged  
7% decrease in potentially preventable visits

**Transitional Supporting Housing**

**OUTCOME**

20 new beds  
26 community-based organizations and hospitals engaged  
24% reduction in inpatient admissions

**Behavioral Health and Primary Care Services Integration**

**OUTCOME**

40 partners and 177,301 patients engaged  
4% increase in antidepressant initiation

**Increase Access to Chronic Disease Prevention and Care**

**OUTCOME**

7% increase initiation and engagement treatment for alcohol and drugs

**Strengthen Mental Health and Substance Abuse Infrastructure**

**OUTCOME**

46 youth mental health first aid trainings  
850 certified individuals  
34 clinicians trained in the Attachment, Regulation, and Competency (ARC) model

**Behavioral Interventions Paradigm in Nursing Homes**

**OUTCOME**

39 skilled nursing facilities and 4,214 patients engaged  
34% reduction in long-term care resident reports of depression  
27% reduction in antipsychotic medication use among residents with dementia

**Care Transitions**

**OUTCOME**

34 partners and 26,517 patients engaged  
2% decrease in potentially preventable visits

**Maternal and Child Health**

**OUTCOME**

2,797 patients engaged  
29 community health workers  
3% reduction in low birth weight

**Community Navigation and Patient Activation**

**OUTCOME**

108,609 patients engaged in patient activation measure

**Behavioral Health Community Crisis Stabilization**

**OUTCOME**

57 partners and 40,654 patients engaged  
16% reduction in preventable emergency department visits for individuals with a behavioral health diagnosis

**EARLY ADOPTERS**

- Jordan Health
- Arnot Health
- Blossom View Nursing Home
- Finger Lakes Community Health
- Oak Orchard Health
- Mosaic Health
- Rochester Regional Health
- Pivotal Public Health Partnership
- Steuben County Department of Social Services
- University of Rochester Medical Center

Successfully leading the region’s DSRIP implementation allowed FLPPS to develop a unique set of expertise:



**A TRUSTED PARTNER**

A key component to leading a healthcare delivery system transformation project across a 13-county region was the development of trusting relationships with each partner.

FLPPS built trusting relationships with and among individual partners to lay the foundation for a network that would come together around aligned goals and implement a ground-breaking project.



**PROJECT MANAGEMENT**

FLPPS DSRIP award of \$530 million was the second largest dollar value across the entire state due to the impressive scope and scale of our DSRIP application and region-wide impact.

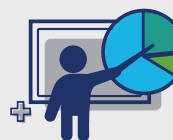
Our project management skills enabled the achievement of 99% of the dollars awarded in connection with patient engagement and project milestone achievement.



**COLLABORATIVE LEADERSHIP**

FLPPS fostered a sense of collaboration and trust among the partners by convening over 25 diverse stakeholder groups that participated in the implementation of the DSRIP program.

With a focus on community collaboration, we managed network relationships, we regarded each individual participant with respect, and convened the stakeholder groups with transparency and accountability.



**STRATEGIC PLANNING**

FLPPS has proven itself a leader in strategic planning initiatives across our region.

Our expertise in facilitation, system transformation, and value-driven solutions helped guide 12 not-for-profit human service agencies through our 18-month CBO Value-Based Payment Readiness Program to develop their strategic plans and value statements through organizational assessment, gap analysis, performance improvement strategy and implementation plan, and value-proposition statement.

FLPPS is grateful for all the team members, staff, stakeholders, committee and workgroup members, partners, supporters, consultants, and contractors whose collaboration over the years was instrumental in the development and implementation of the DSRIP program, making it a resounding success in our region.

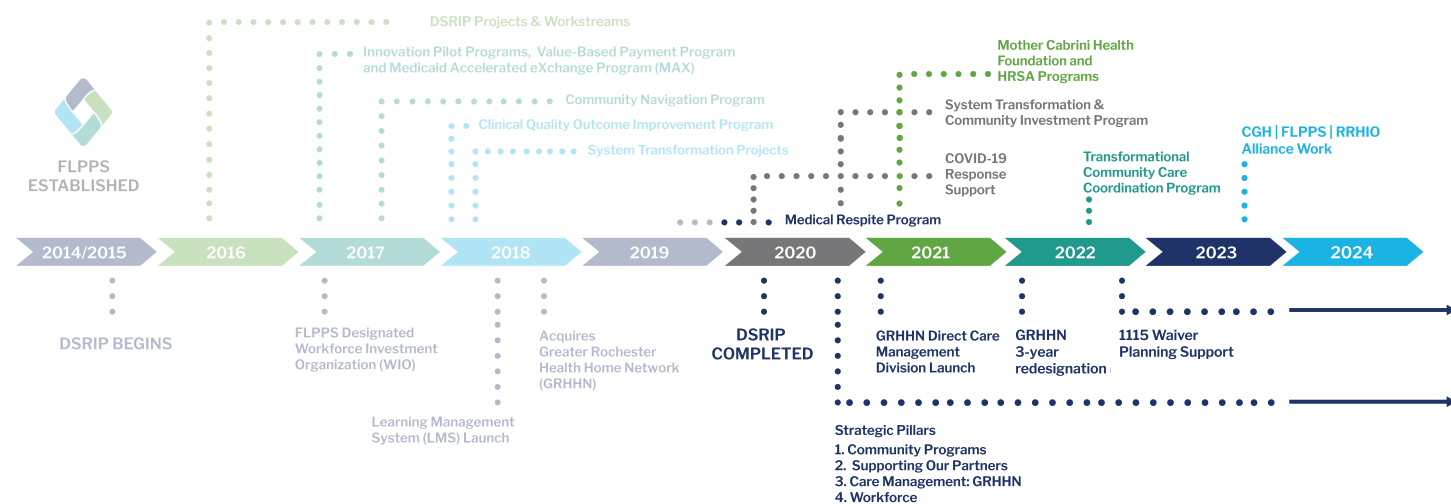
# Continuing to Drive System Transformation Through Four Strategic Pillars

FLPPS continues to drive transformation in the region post-DSRIP by promoting successful DSRIP programs and managing new, innovative efforts that bridge the gaps between community and healthcare, and addressing social, racial and health inequity gaps that have been highlighted by the COVID-19 pandemic.

We played an integral role in the region's pandemic response, devoting significant resources at local testing sites, organizing vaccine distribution, and educating the community about COVID-19. Our rapid deployment of IT equipment to community-based organizations enabled the shift to a remote work environment.

The pandemic also intensified the significant healthcare workforce challenges. Since DSRIP's onset, FLPPS has been at the forefront of addressing workforce recruitment, training, and retention issues, as a New York State designated Workforce Investment Organization.

Moving forward, we continue to use what we learned from DSRIP and the pandemic to further efforts that will help our partners and stakeholders to deliver better care and address health inequity.



FLPPS now focuses on transforming healthcare with our partners under four strategic pillars:



## COMMUNITY PROGRAMS

We are building on and continuing healthcare system transformation work through large-scale programs such as the System Transformation and Community Investment, and the Transformational Community Care Coordination programs.



## SUPPORTING PARTNERS

We are advancing our mission to improve the Medicaid healthcare delivery system through the collaborative relationships we have formed with partners and stakeholders in our region.



**grhnn**  
Greater Rochester Health Home Network

## CARE MANAGEMENT: GREATER ROCHESTER HEALTH HOME NETWORK (GRHNN)

We provide care management and care coordination, with a specific focus on addressing social determinants of health through our subsidiary organization, the Greater Rochester Health Home Network.



## WORKFORCE

We are a New York State-designated Workforce Investment Organization focused on strengthening the healthcare workforce through programs and services.

# Community Programs

Incorporating lessons learned from DSRIP Promising Practices, we have invested in advancing targeted interventions that leverage community-based organizations to improve health outcomes.

Our projects address efforts to improve health outcomes in **behavioral health, maternal and child health, social determinants of health, and care management**, which were prioritized using a data-driven needs analysis of clinical outcome performance.

More than 20 best practice interventions and 30 partners established or expanded programming to address these outcomes over a 2-to-3 year project timeframe, with specific milestones and deliverables. Program evaluation is a key component of this programming to work toward sustainability.

Our projects also address the public health crisis of overcrowding in Monroe County hospitals with an innovative model to support the long-term care sector experiencing workforce, financial, and bed capacity challenges.

In 2023, FLPPS received \$11 million in American Rescue Plan Act (ARPA) funding from Monroe County to address long-term care staffing shortages. Approximately \$5.5 million was allocated to the FLPPS Long-Term Care Workforce Program, and \$5.5 million was allocated to a workforce development partnership with FLPPS and Monroe Community College for their Transforming Lives Through Nursing Pathways Program.

## TRANSFORMATIONAL COMMUNITY CARE COORDINATION PROGRAM

The Transformational Community Care Coordination (TC3) Program addresses the current public health crisis in our community by collaboratively transforming the healthcare delivery system and revitalizing our community's healthcare workforce.



### COMPLEX CARE PROGRAM

The Complex Care Program addresses the barriers to discharging patients to nursing homes and alleviates a backlog of hospital patients who no longer need acute care but cannot find appropriate placements in nursing homes.



### LONG-TERM CARE WORKFORCE PROGRAM

The Long-Term Care Workforce Program addresses critical workforce shortages in long-term care through career pathway systems and recruitment, training, and retention activities.

## SYSTEM TRANSFORMATION AND COMMUNITY INVESTMENT PROGRAM

The System Transformation and Community Investment (STACI) Program is a portfolio of projects focused on integrating community-based care into the healthcare delivery system and supporting community-based organizations in programming designed to positively impact health outcomes, health equity, and the cost of healthcare.



### BEHAVIORAL HEALTH

Innovative initiatives to engage and support behavioral health care collaborative networks and individual providers in building program capacity, connections to primary care, integrating peer support services, and implementation of quality improvement initiatives that improve behavioral health outcomes.

- His Branches Community Health Center & Ibero-American Action League
- City of Rochester Crisis Intervention Services
- Exercise Express: Support for Individuals with Behavioral Health Needs
- Peer Integration with Crisis Intervention Services
- Behavioral Health Care Collaboratives



### SOCIAL DETERMINANTS OF HEALTH

Supporting high-need patients and assisting providers in providing care by addressing social determinants of health factors. The efforts include advancing health equity by working with sectors on the factors that influence health, including employment, housing, public safety, and food access.

- Foodlink Maternal Home Delivery Program
- Food Bank of the Southern Tier and C.I.D.S. Maternal Kitchen Stork Home Delivery Program
- Street Medicine Program
- Backpack Medicine Program
- Healthcare for the Homeless Programs

The projects are based on the United Hospital Fund "FLPPS DSRIP Promising Practices: Strategies for Meaningful Change for New York Medicaid" report, as well as FLPPS DSRIP promising practices, and represent targeted interventions, which leverage community-based organization expertise to improve outcomes in a sustainable manner.



### CARE MANAGEMENT

Improving population health and reducing avoidable emergency room and hospitalizations for high-needs populations, initiatives in this domain provide for care management in response to patient level of need through patient-centered medical homes, community navigation, and health homes. Activities include outreach and engagement with high-needs populations.

- Lifespan Expanding Services for Older Adults



### MATERNAL AND CHILD HEALTH

Providing new models of care to address a wide range of conditions, health behaviors, and indicators that affect the health, wellness, and quality of life of women, infants, children, and families.

- Children's Institute "Get Ready to GROW" Program
- Community-Based Doula Program



## Supporting Partners

Our expertise in integrated healthcare delivery system optimization, care management, network and program management, project management, population health, data analytics, performance improvement and evaluation, and workforce and learning and development continues to flourish and is enhanced with our community partnerships.

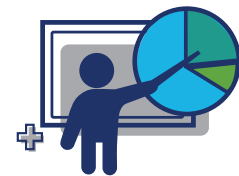
We value the collaborative relationships we have formed with partners and community stakeholders in our region, as we believe these strategic partnerships differentiate use in terms of network experience and opportunity for collaboration.

Partners leverage our expertise in the implementation of their programs and services.



### PROGRAM MANAGEMENT SUPPORT

We provide consultative services related to program and project management, workflow redesign and documentation, data analytics, and evaluation and performance improvement.



### STRATEGIC CONSULTING

We provide strategic consulting services that can include facilitating strategic planning sessions, project management, data analytics and benchmarking, independent provider association (IPA) subject matter expertise, and general administrative support.



### GRANT MANAGEMENT SUPPORT

FLPPS provides professional, technical, and administrative services as a lead agency for federal and private foundation grants. This includes program management support, fiscal management and oversight, and reporting.



### COVID-19 SUPPORT

We leveraged strong community collaborations developed through the DSRIP program to mobilize and respond quickly and effectively to the COVID-19 crisis. Numerous efforts took place in response to the COVID-19 pandemic and many are still underway.

## Care Management

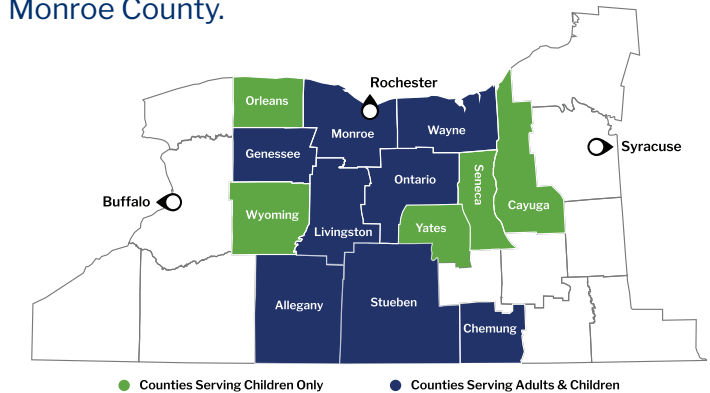
The Greater Rochester Health Home Network (GRHHN) was acquired by FLPPS in 2018 and serves as a lead Health Home administering the New York State Health Home program, which provides a care management benefit for high-risk Medicaid patients.

The GRHHN's work is part of a coordinated effort to improve care among a vulnerable population, by connecting individuals with primary care providers, hospitals, behavioral health services, and community-based organizations, and helping individuals with follow up, access, and addressing social determinants of health.

In addition, the GRHHN established a Direct Care Management division to supplement the care management capacity in the region and support partner outreach and population health management for high-risk patients, which has resulted in increased continuity of care, reduced system costs, improved outcomes, and reduced burdens in emergency departments.

The GRHHN is an active member of the New York Health Home Coalition, which represents the leadership of health home in New York State and provides advocacy and strategic direction across the state.

With FLPPS infrastructure expertise and knowledge, the GRHHN continues to improve operational efficiencies, outcomes for enrolled patients, and care management agency satisfaction, increasing enrollment in its geographic coverage beyond Monroe County.



### GRHHN MEMBER IMPACT

**73% LINKED TO PRIMARY CARE**  
who previously didn't have a PCP

**75% OBTAINED STABLE HOUSING**  
after being homeless

**89% ACHIEVED STABLE HOUSING**  
after feeling they may lose their home

**100% REMEDIED UTILITY ISSUES**  
in their home

**64% IMPROVED TRANSPORTATION**  
to and from appointments

*“Community partners must unite to support our most vulnerable and underserved communities. Despite limited funding and staff at health centers and non-profits, this unified approach can begin to close the health disparities gap and build a healthier community.”*

Linda Clark, MD, President & CEO  
Jordan Health

# Workforce

Workforce shortages have been exacerbated by the pandemic and underscore the critical need to create a strong, equitable, and high-performing workforce development system.

FLPPS and its partners understand the need for a skilled and diverse healthcare workforce, which is why workforce development has been a primary focus of FLPPS since its inception.

Building on our DSRIP workforce work stream, we leverage our capabilities as a New York State-designated Workforce Investment Organization (WIO) to strengthen and ensure there is a highly-skilled and sufficient healthcare workforce to serve the Finger Lakes Region.

During DSRIP, FLPPS, along with its partner Common Ground Health, convened education and employer partners across the region to analyze the current state of the healthcare workforce, understand the impact of the DSRIP program on workforce roles and responsibilities, and track training and retraining efforts, as well as identify workforce gaps.

Now, collaborating with healthcare employers, higher education institutions, training organizations, and community-based organizations, FLPPS co-designs programs that provide for education and economic mobility through career pathways and social supports, expands curriculum offerings, and include tailored outreach, recruitment, and engagement in the training programs.

Tying lessons learned during the course of DSRIP with its WIO role, FLPPS has learned that many barriers to health are the same barriers to employment. There is a significant need to provide wraparound support to alleviate multiple disadvantages and barriers faced by low-income employees or students pursuing a career in healthcare. Successful completion at each level empowers individuals and families toward economic stability and increases the retention of valuable workers within the regional healthcare workforce.

*“A robust and sustainable healthcare workforce is critical to improving population health—**with no workforce, there is no healthcare.**”*

A cornerstone of FLPPS programming, FLPPS leads the region’s healthcare workforce strategy in partnership with Common Ground Health.

FLPPS workforce development programs expand and diversify the healthcare workforce pipeline and provide opportunities for those who may not otherwise have them, all while supporting the community’s economic mobility.



### NYS MANAGED LONG-TERM WORKFORCE INVESTMENT PROGRAM

We partnered with 3 Medicaid managed long-term care plans on numerous initiatives designed to retrain, recruit, and retain healthcare workers in the long-term care sector.



### WORKFORCE PROGRAMS

We have brought together partners and developed programs that expanded curriculum offerings, career pathways and social support programs, and tailored outreach, recruitment, and engagement in the training programs. We also support anti-racism and diversity programming in the employer setting.

### WORKFORCE PROGRAMMING IMPACT TO REGION\*

- More than **200** Home Health Aides
- Nearly **1,300** Certified Nursing Assistants
- Nearly **400** Licensed Practical Nurses
- More than **115** Registered Nurses
- Nearly **30** Credentialed Alcoholism & Substance Abuse Counselors

\*As of July 2024



### LEARNING MANAGEMENT SYSTEM

Our Learning Management System has become a valuable community asset that is used by a growing number of partners. The course catalog continues to expand in response to the training needs of our partners and community.

*“By focusing on training centered around career development and supporting socio-economic challenges faced by those starting entry level roles, **we have increased the workforce to better meet the needs of our community.**”*

Suzanne Turchetti, President  
HCR Home Care

# Capital Restructuring Financing Program

In 2016, FLPPS was awarded a \$12 million Capital Restructuring Financing Program (CRFP) grant from the Dormitory Authority of NYS (DASNY) and NYS Department of Health through our partner, Finger Lakes Community Health.

The purpose of the CRFP funds was to complement the goals of the DSRIP Program for capital information technology (IT) projects related to partner IT enablement, transitions of care, community care coordination, and telehealth.

CRFP funds were used to support capital projects that helped strengthen and promote access to essential health services, including projects to improve infrastructure, promote integrated health systems, and support the development of additional primary care capacity.

This grant was made possible with a \$27.5M match of funds spent by FLPPS and partners on IT/ infrastructure-related projects.



**130+**  
organizations impacted

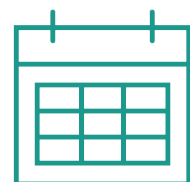


**4,000+**  
laptops purchased

**Dozens**  
of physical servers



**20+**  
access points and wireless  
network improvement projects



Equipment distributed  
**May 2022 - May 2024**

*“The CRFP grant partially funded a network hardware refresh that we desperately needed. The project, in conjunction with switching our Internet Service Provider, will result in improved network performance and reliability for our staff (and clients) at all of our sites. Thank you.”*



*“These funds have made a huge impact on our agency and our ability to serve our customers. Funds were used to install a modern phone system which has greatly improved our customer’s ability to reach the right people for help. You have my sincerest gratitude.”*

*“This is truly remarkable. **The impact this has on our small organization cannot be overstated.** With the increasing demands to fortify our cyber security practices, we’ve seen a corresponding rise in costs for ongoing IT support, for updated/advanced software, and for escalating insurance expenses, among others. Having some of our hardware costs covered is an immense relief. Thank you!”*



*“This grant has been extremely helpful to JHR, we were able to replace 2 aging firewalls, many aging desktops and IP phones, as well as overhauling our backup infrastructure. **Given the constant threat and oftentimes follow through of Medicaid cuts to nursing homes, this funding really helped us offset much needed IT infrastructure costs.**”*

*“The FLPPS grant has enabled [us] to divert some of the funds we would normally spend on hardware to some innovative projects that directly benefit the individuals we serve. We have also been able to fund some further data security and compliance initiatives that we were unable to get to in the recent past. We greatly appreciate the grant and those that we have worked with at FLPPS.”*



*“The CRFP grant played a pivotal role in fortifying St. Ann’s Community’s disaster recovery system. With the funding, we were able to invest in state-of-the-art technology, implement robust backup solutions, and develop comprehensive contingency plans by purchasing a server system for a 2nd physical location. This not only strengthened our ability to mitigate potential risks but also ensured seamless operations and minimal downtime in the face of unforeseen disasters, safeguarding both residents and organizational continuity.”*



# Redesigning Medicaid Healthcare Delivery in the Finger Lakes Region

FLPPS work today is building on our successful implementation of DSRIP and continuing transformative work with our partners to achieve the newly coined “Quintuple Aim”—improving patient experience, improving population health, reducing healthcare costs, improving care team well-being, and advancing health equity.

Our collaborative relationships and strategic partnerships with regional partners and stakeholders, along with our highly-skilled team, enable us to continue the successful implementation of transformational programs today, tomorrow, and in the future.

**“Delivery system redesign is comprehensive and complex, however, each component is a single and *necessary* step that we must collectively take towards system transformation.”**

**LEARN MORE**



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*Roster as of July 2024  
\*FLPPS Executive Committee Member*

**“We are not just redesigning healthcare. We have the opportunity to *redefine* healthcare.”**

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For more information about FLPPS and GRHHN, please visit us online at [flpps.org](http://flpps.org)

FLPPS is a network of clinical and community-based provider organizations working together in a 13-county region to transform the system of healthcare delivery by bridging the gap between community and healthcare.