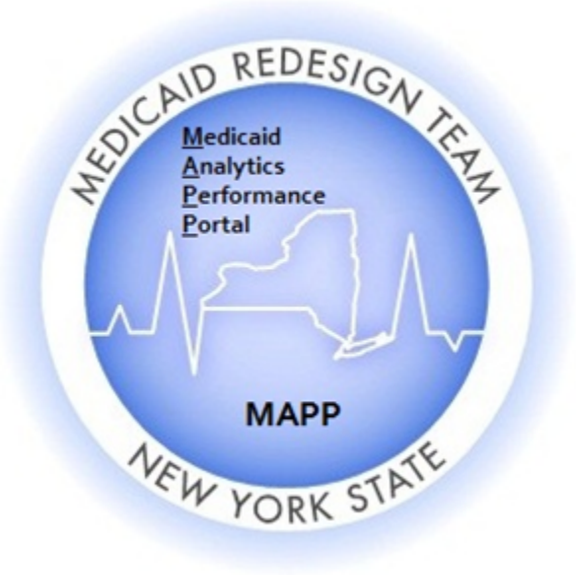
New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP PPS Organizational Application



Richmond Univ Med Center & Staten Island Univ Hosp

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

DSRIP PPS Organizational Application

Richmond Univ Med Center & Staten Island Univ Hosp (PPS ID:43)

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This application is divided into 11 sections: Sections 1-3 and 5-11 of the application deal with the structural and administrative aspects of the PPS. These sections together are worth 30% of the Total PPS Application score. The table below gives you a detailed breakdown of how each of these sections is weighted, within that 30% (e.g. Section 5 is 20% of the 30% = 6 % of the Total PPS Application score).

In Section 4, you will describe the specific projects the PPS intends to undertake as a part of the DSRIP program. Section 4 is worth 70% of the Total PPS Application score.

Section Name	Description	% of Structural Score	Status
Section 01	Section 1 - EXECUTIVE SUMMARY	Pass/Fail	Completed
Section 02	Section 2 - GOVERNANCE	25%	Completed
Section 03	Section 3 - COMMUNITY NEEDS ASSESSMENT	25%	Completed
Section 04	Section 4 - PPS DSRIP PROJECTS	N/A	Completed
Section 05	Section 5 - PPS WORKFORCE STRATEGY	20%	Completed
Section 06	Section 6 - DATA SHARING, CONFIDENTIALITY & RAPID CYCLE EVALUATION	5%	Completed
Section 07	Section 7 - PPS CULTURAL COMPETENCY/HEALTH LITERACY	15%	Completed
Section 08	Section 8 - DSRIP BUDGET & FLOW OF FUNDS	Pass/Fail	Completed
Section 09	Section 9 - FINANCIAL SUSTAINABILITY PLAN	10%	Completed
Section 10	Section 10 - BONUS POINTS	Bonus	Completed

By this step in the Project you should have already completed an application to designate the PPS Lead and completed various financial tests to demonstrate the viability of this organization as the PPS Lead. Please upload the completed PPS Lead Financial Viability document below

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

Currently Uploaded File: **43_SEC000_SIUH RUMC DSRIP Finacial Stress Test Excel Sheets For DSRIP Download.pdf**

Description of File

SIUH and RUMC Financial Stress Test Excel Tool Sheets

File Uploaded By: rb426896
File Uploaded On: 12/21/2014 04:44 PM

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

Section 11 will allow you to certify your application. **Once the application is certified, it will be locked.**

If you have locked your application in error and need to make additional edits, or have encountered any problems or questions about the online Application, please contact: DSRIPAPP@health.ny.gov

Last Updated By: rb426896
Last Updated On: 12/22/2014 04:37 PM

Certified By: jc484356
Certified On: 12/22/2014 04:43 PM
Lead Representative: Joseph G Conte

Unlocked By:
Unlocked On:

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SECTION 1 – EXECUTIVE SUMMARY:

Section 1.0 - Executive Summary - Description:

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

Scoring Process:

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

Section 1.1 - Executive Summary:

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

#	Goal	Reason For Goal
1	Develop an infrastructure that achieves transformation by investing in technology, tools, and human resources.	Staten Island PPS providers require additional tools, technology, and resources to better serve patients in a more efficient way. The DSRIP investment in infrastructure will enable the improvements in communication and care delivery required to meet DSRIP goals and ensure the program is sustainable.
2	Expand access to the appropriate level of care and reduce barriers to care for all patients.	SI is comprised of an ethnically diverse population, presenting linguistic and cultural barriers for Medicaid enrollees and the uninsured attempting to self-manage care and access and navigate SI's healthcare provider system
3	Expand outpatient and community services to reduce avoidable hospital/Emergency Department use.	The PPS will strengthen and expand outpatient services including home care, ambulatory detox, behavioral health/substance abuse and primary care to provide to reduce avoidable admissions, readmissions, and ER visits.
4	Improve the overall health of the community on Staten Island.	The overall goal of transforming care across SI will be improve the overall health of the community for Medicaid patient, the uninsured, and all patients.
5	Improve coordination of care / develop an integrated network	SI PPS partners and patients report a need to better coordination services and communication across SI's provider network will limit inappropriate utilization of services and improve overall care.
6	Improve care management for high risk patients, including patients with chronic acute and behavioral conditions.	The PPS believes providing high-risk patients with chronic conditions or other risk factors with individualized care management services through a coordination care plan in collaboration with an integrated care team will allow patients to better manage their care and direct patients to appropriately utilize services.
7	Develop population health care capacity	The ability to perform population wide analytics and risk stratification to proactively identify patients and effectively prioritize outreach activities and interventions is critical to improving health outcomes and reducing avoidable hospital use.
8	Integrate technology to allow for the secure exchange of health information across PPS providers.	The SI PPS strongly believes that the ability for providers to share information is central to the overall strategy for reducing hospital admissions by improving coordination and integration of the care continuum.
9	Reduce per person costs for providing care.	Through achieving the appropriate utilization of services for Medicaid beneficiaries and the uninsured, the PPS will work to reduce healthcare expenditures.
10	Engage the uninsured and low utilizing Medicaid patients and connect them to care.	For any healthcare transformation to be successful the PPS must provide enhanced quality of care to current patients, and must also engage patients that are low/non-utilizers or uninsured to connect them to the appropriate

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#	Goal	Reason For Goal
		prevention and management services.
11	Implement innovative and evidence based care models throughout the care continuum.	To improve the overall care delivery for patients on SI, PPS providers will test and implement innovative and evidence based care models and protocols across the PPS.
12	Implement learning collaboration between PPS partners for sharing best practices across the system.	The PPS will build upon collaboration that has begun during the DSRIP planning process to develop PPS wide training programs that allow for the sharing of best practices and innovative approaches across the PPS to drive quality improvement for all patients.

***Formulation:**

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

Staten Island (SI) is a comparably smaller market for healthcare services in the New York City (NYC) metropolitan area with a history of provider collaboration and a shared understanding of the community among health, social service, and community-based organizations, making SI favorable to achieve population-based healthcare through a more integrated delivery system. The hospitals on SI, Richmond University Medical Center (RUMC) and Staten Island University Hospital (SIUH), that combined have 86% of all Medicaid discharges, and 90% of self-pay discharges, will act as Co-Leads to the Staten Island PPS (SI PPS). Without the PPS, SI, which does not have a public (HHC) acute care hospital, would not be adequately served by the DSRIP program. Congruent with the goals of DSRIP, it is compelling to have a Co-lead DSRIP project by the borough's only two hospitals. To implement and manage the SI PPS, a NewCo will be formed, led by RUMC and SIUH, where PPS partner organization members will have ongoing input and a formal role in the NewCo governance and management structure allowing providers and community members to have an ongoing input into the implememtation of the DSRIP progrogram.

***Steps:**

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

The SI PPS' central goal will be the transformation into a more integrated delivery system where care is properly coordinated across the continuum of care through aligned goals and incentives, and through an IT infrastructure that allows providers to share health information and communicate across providers. This goal will be achieved through the development of an infrastructure that lays the foundation for delivery system transformation including technology, tools and resources that strengthen the provider system and allow sustainability after the 5 year DSRIP program. The transformation will also support the delivery of care in the right setting, at the right time, for the right cost, strengthening outpatient and community based services. The PPS through NewCo will also evolve, in partnership with Managed Care Organizations (MCOs) to accept risk based contracts and other value based reimbursement arrangements.

***Regulatory Relief:**

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

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

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

PPS' should be aware that the relevant NYS agencies may, at their discretion, determine to impose conditions upon the granting of waivers. If these conditions are not satisfied, the State may decline to approve the waiver or, if it has already approved the waiver, may

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withdraw its approval and require the applicant to maintain compliance with the regulations.

#	Regulatory Relief(RR)	RR Response
1	PHL §2807(20)(e) and (21)(e) and (21)(e)	The PPS will require a corporate structure that incorporates some allowances related to the Corporate Practice of Medicine.
2	10 NYCRR 600.9(c)	The DSRIP program provides for each PPS to receive DSRIP incentive payments and distribute those funds to participating partners and others, in accordance with a funds flow approach outlined in the SI PPS DSRIP Application. It is conceivable that an Article 28 entity serving as a co-leader or a participating provider might receive DSRIP Funds for re-distribution to others providers and entities within the PPS. To facilitate smooth operation of the PPS and the processing of DSRIP funding, the SI PPS requests a waiver of Reg. 600.9(c), which limits the sharing of "total gross income or net revenue of a medical facility." In case DSRIP funds would come within this definition, and to permit sharing of DSRIP funds received by hospitals or other Article 28 facilities in accordance with the SI PPS funds flow methodology, a waiver should be granted. This impacts general PPS operations, and would have no impact on patient safety.
3	Waiver of Limitations on Billing for Multiple Services on the Same Day	Scheduling primary care and psychiatry visits on the same day is more convenient for patients, and may affect Project 3.a.i (Integration of Medical and Primary Care) and other projects seeking to provide multiple services as efficiently as possible to high risk patients. Payment for same day, multi-specialty billing is needed, and especially for any guidance or regulations that support MCO protocols that limit payment for same day services.
4	Issue Waivers/ Simplify Approvals For Co-Location of Behavioral Health and Primary Care Services	DSRIP Project 3.a.i involves the integration of Primary and BH Services. In addition to physical plant issues (i.e. Interchangeable offices), flexible staffing, and billing, waiver or expedited reviews will be required in order to permit primary care facilities to add behavioral health services, and vice versa. Specifically, wavier is requested of DOH Reg. 401.3(d), and similar OMH and OASAS regulations. In addition, Proposed OMH Reg. 14-599-1 should add provisions for an expedited process and for recognition of the combined services for reimbursement purposes. This would have no impact on patient safety.
5	(CMS/other regulations) Limitation on ability for Nurse Practitioner's to prescribe suboxone	Flexibility around the limitation on suboxone patients and the ability for Nurse Practitioners to prescribe suboxone will be important in furthering the goal of the PPS in expanding ambulatory detox (Project 3.a.iv Ambulatory Detox/Withdrawal Management).
6	OASAS guidelines for outpatient withdrawal managements	Waivers that provide flexibility around existing OASAS guidelines to accommodate less restrictive ambulatory detox staffing ratios will support the PPS's ability to expand ambulatory detox (Project 3.a.iv Withdrawal Management).
7	10 NYCRR Part 790	This would expand the geographic areas in which hospices are authorized to operate. This will impact the PPS's ability to implement palliative care expansion through hospice providers not currently licensed to practice on SI through project 3.g.ii.
8	10 NYCRR 400.9 , 400.11, 700.3, 18 NYCRR 505.20, 14 NYCRR 36.4, 14NYCRR 504.5, 14 NYCCRR Part 815.7	To ease the transition of patients between care levels pursuant to Project 2.b.iv (Care Transitions), Project 2.b.vii. (Hospital-Home Care Collaboration), Project 3.a.iv (Ambulatory Detox) and Project 2bvii. (INTERACT), the SI PPS will require waivers pertaining to admission, discharge and transfer of patients. All decisions about facility placement are ultimately subject to patient choice.
9	10 NYCRR 401.2(b)	This would enable individuals with chronic illnesses to be visited at home by practitioners employed by the general hospital OP departments and D&TCs. This would be important for Projects 2.b.vii (Hospital-Home Care Collaboration) and 2.b.iv (Care Transitions). Care management is a key element of many of the DSRIP projects, and with the DSRIP target population; it is likely that some of the elements of care management and project implementation may be best accomplished through home visits by physicians, nurses, care managers and other staff from PPS participating

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#	Regulatory Relief(RR)	RR Response
		partners. This waiver does not implicate patient safety, since licensed facilities or professionals in those fields would provide all services requiring professional licensure.
10	(CMS/federal regulations) Limitation on ability for Nurse Practitioners (NP) to authorize homecare	Waivers that provide flexibility around existing limitations on the ability of NP's to authorize homecare will assist the PPS in meetings is goals of reducing admissions for patients in home care that are at risk for readmission.
11	Limitations on reimbursement for home visits	Waiver for 10 NYCRR 86-4.9, 86-8.14, and 401.2, would allow for consideration of reimbursement of home visit types of services which are important to 2.b.vii (Hospital-Home Care Collaboration) and 2.b.iv (Care Transitions).
12	10 NYCRR 405.9(f)(7))	DOH Reg. 405.9(f)(7) requires hospitals to "ensure that no person presented for medical care shall be removed, transferred or discharged from a hospital based upon source of payment." In view of the potential that the incentive payments for DSRIP Projects could come within the Reg. 405.9(f)(7)'s definition of source of payment, SI PPS requests a waiver of that regulation, so that there can be no question that the SI PPS and its providers can pursue the DSRIP Projects that seek to improve care management and could impact discharge and transfer decisions without violating this regulation. This would affect transferring patients for more appropriate services in many of the DSRIP projects including 3.a.iv. Ambulatory Detox.
13	Waiver and Expedition of Construction Regulations	To facilitate construction and placing renovated facilities in service as quickly as possible, the SI PPS requests that the agencies expedite approvals or waive CON, PAR and other approvals and permit architectural self-certification, and similarly waive the need methodology for construction and equipment purchases related to DSRIP projects, Regulations potentially to be waived are DOH Reg. 401.3, 712-2.4, 713-4.3, 713-4.4, 713-4.9, 713-4.10 714.4, 715-2.4, 717.2; OMH Regs 599.5 and 599.12; and OASAS Regs. 814.2, 814.3, 814.6 and 814.7. Patient safety will not be impacted, if self-certification is permitted. These waivers impact on Project 3.a.i (Integration of Primary and Behavioral Health Services) and possibly others in which construction may be required at one or more PPS provider locations.
14	Waiver of Regulations Limiting Changes in Capacity on Operating Certificates	While the agencies have reduced the number of service changes that require CON or other reviews, we request that the agencies waive or expedite approvals of changes in services to the extent necessary to implement a DSRIP Project. Examples include adding behavioral health services at an FQHC site under Project 3.a.i, and possibly others where there will be a shift in utilization from inpatient to community based services. Waivers would include: DOH Reg. 710.1 OMH Reg. 551 pertaining to prior approval review for quality and appropriateness; and OASAS Reg. 810 pertaining to establishment, incorporation and certification of providers of chemical dependence services.
15	Waiver or Expedited Scheduling of Pre-Opening Surveys	In order to make facilities available as soon as construction or renovations are completed, we request that the agencies waive pre-opening inspections or expedite scheduling of pre-opening inspections for renovations or construction in existing facilities that otherwise would be required under DOH Reg 710.9. This affects projects in which construction may be required at one or more PPS provider locations. Patient care issues can be addressed by architectural self-certifications and the fact that the waiver would be for projects in already licensed and inspected facilities.
16	NYCRR 400.11 and 700.3	This regulation governs the assessment of Long Term Care patients. Waivers will be beneficial as it relates to the goals of Project 2bvii. INTERACT.
17	NYCRR 405.19(g)	The PPS members will pursue waivers regarding limitation on the number of observation beds, and certain approvals as it may support the overall goals of DSRIP to reduce avoidable admissions.

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#	Regulatory Relief(RR)	RR Response
18	Telemedicine/Telehealth	Telemedicine allows for clinic access for clients where travel to a clinic is difficult or impossible, especially in rural areas, for patients who have difficulty travelling, or in areas where transportation is difficult; allows immediate clinic access when a rapid evaluation is needed; and allows a patient in a primary care office to access psychiatry through telemedicine. Currently proposed changes to OMH regulations 599.17 involving telemedicine do not provide sufficient regulatory relief as it requires that both the client and the prescriber must physically be in an OMH clinic. Similarly, DOH regulations should be waived or amended to permit telemedicine between non-Article 28 sites. Telemedicine will assist with Project 2.b.iv (Care Transitions to Reduce 30 day admissions), 2.di (Engage Medicaid low/non users and the uninsured) and other clinical projects. These waivers will enhance patient safety, as they will permit more timely evaluation of patients' conditions, and reduce avoidable ED visits.
19	Waiver of Regulations and Guidelines to Facilitate Information Sharing	Although the agencies have indicated that a simple waiver is not available for this issue, we understand that DOH, OMH and OASAS plan to coordinate on the development of a model information release consent form for use by PPS providers that would cover all forms of patient information exchanged by providers. In that process, to facilitate information sharing among providers in connection with care management and other PPS collaborations, we suggest that the agencies seek clarification of SHIN-NY guidance be issued to facilitate information sharing, including "opt-out" approaches for clinical information exchange, and clarification that sharing of information among PPS Participating Providers in connection with DSRIP constitutes permitted sharing of information for treatment purposes that does not require consent. Impacts all projects that incorporate patient engagement, care management and outreach. There is no impact on patient safety.
20	Waiver of 10 NYCRR 405.3(f) Regarding Management Contracts	SI PPS, LLC and its PMO will be providing a range of services to the partners, including coordination of care management, support in project implementation, collection and analysis of data, and other PPS administrative functions. While SI PPS does not view these centralized functions as constituting traditional "management contracts," and while each facility will retain its existing governance and management structure, services provided by the PMO might be viewed as "management" services that might require DOH approval under DOH Reg. 405.3 initially and every 3 years. Waiver is sought so that it will be clear that DOH approval of PPS administrative activities do not require such approval. This waiver may affect multiple projects involving the support and coordination of the SI PPS PMO. This waiver would not have any impact on patient safety because all patient services will be provided by licensed facilities and practitioners who remain subject to applicable regulations concerning their patient care activities.

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SECTION 2 – GOVERNANCE:

Section 2.0 – Governance:

Description:
An effective governance model is key to building a well-integrated and high-functioning DSRIP PPS network. The PPS must include a detailed description of how the PPS will be governed and how the PPS system will progressively advance from a group of affiliated providers to a high performing integrated delivery system, including contracts with community based organizations. A successful PPS should be able to articulate the concrete steps the organization will implement to formulate a strong and effective governing infrastructure. The governance plan must address how the PPS proposes to address the management of lower performing members within the PPS network. The plan must include progressive sanctions prior to any action to remove a member from the Performing Provider System.

This section is broken into the following subsections:

- 2.1 Organizational Structure
- 2.2 Governing Processes
- 2.3 Project Advisory Committee
- 2.4 Compliance
- 2.5 Financial Organization Structure
- 2.6 Oversight
- 2.7 Domain 1 Milestones

Scoring Process:

This section is worth 25% of the total points available for the Overall PPS Structure Score. The responses will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.

- 2.1 is worth 20% of the total points available for Section 2.
- 2.2 is worth 30% of the total points available for Section 2.
- 2.3 is worth 15% of the total points available for Section 2.
- 2.4 is worth 10% of the total points available for Section 2.
- 2.5 is worth 10% of the total points available for Section 2.
- 2.6 is worth 15% of the total points available for Section 2.
- 2.7 is not valued in points but contains information about Domain 1 milestones related to Governance which must be read and acknowledged before continuing.

Section 2.1 - Organizational Structure:

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

***Structure 1:**
Outline the organizational structure of the PPS. For example, please indicate whether the PPS has implemented a Collaborative Contracting Model, Delegated Model, Incorporated Model, or any other formal organizational structure that supports a well-integrated and highly-functioning network. Explain the organizational structure selected by the PPS and the reasons why this structure will be critical to the success of the PPS.

The Staten Island PPS will implement a Delegated Governance Model to govern the DSRIP PPS network. Under the Delegated model, a newly formed limited liability company , the Staten Island Performing Provider System, LLC, (SI PPS, LLC) consisting of two members, Staten Island University Hospital (SIUH) and Richmond University Medical Center (RUMC), will oversee the PPS. Day to day operations of SI PPS, LLC will be vested in a Board of Managers ("Board") appointed by the two members, and certain fundamental decisions will be reserved for member vote. A Steering committee comprised of representation from over 50 providers including Skilled Nursing Facilities, mental health and substance abuse providers, home care agencies, primary care practitioners, Federally Qualified Health Centers, and community based organizations (the "PPS Partners") will serve in an advisory role to SI PPS, LLC. Additionally, SI PPS, LLC will be supported by a Project Management Office (PMO) that includes a Project Director and Project Managers to support project implementation as well as staff supporting the overall committee structure. The PMO will also include staff to support the SI PPS, LLC Committees described below, as well as Information Technology staff. The PMO will provide day to day operations support to each of the

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DSRIP projects including coordinating project activities, coordinating data/IT requirements and DSRIP reporting requirements, among others. For purposes of funding allocation and payments, the PPS will apply an allocation formula to distribute DSRIP funds received by SI PPS, LLC to two separate HUBS, one for each SI PPS, LLC member and its PPS Partners, for purposes of funding and payment distribution.

SI PPS, LLC plans to have the following committees (the "Governance Committees"):
- Finance Committee
- Clinical Committee
- Data/IT Committee
- Workforce/HR Committee
- Compliance Committee
- Communication & Marketing Committee
- Diversity & Inclusion Committee

The PPS Partners will also contribute to staffing of the Governance Committees, furthering collaboration within SI PPS, LLC. The SI PPS, LLC and delegated model is necessary with two Co-Lead hospitals, and will provide all elements necessary to provide an integrated, efficient and equitable representative structure to carry out and achieve the DSRIP goals.

In addition, please attach a copy of the organizational chart of the PPS. Please reference the "Governance How to Guide" prepared by the DSRIP Support Team for helpful guidance on governance structural options the PPS should consider.

File Upload: (PDF or Microsoft Office only)

Currently Uploaded File: **43_SEC021_NewCo Org Chart_Final 12 20 2014.pdf**

Description of File

Staten Island PPS Governance Org Chart

File Uploaded By: rb426896

File Uploaded On: 12/21/2014 03:21 PM

***Structure 2:**

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

The Staten Island PPS network is comprised of two acute care hospitals, as well as representation from the broad spectrum of PPS Partners. A large and diversified network of this size requires a centralized governance structure to effectively oversee the management and decision making process.

Within the governance structure, the Steering Committee will provide advisory services to strengthen the SI PPS, LLC's governance. More specifically, the Steering Committee will provide project related consultation to the Board of Managers and serve as advisors to SI PPS, LLC. The responsibilities of the Steering Committee include:

1) Stakeholder Engagement and Communication. The Steering Committee will provide input on stakeholder engagement/communication plan and strategy.
2) PPS Partners. The Steering Committee will assist in the ongoing assessment of PPS Partners' project performance and in developing criteria to add/remove members.
3) Financial Impact Modeling, Funds Flows, and Budgeting. The Steering Committee will advise the Board in the development of a funds flow model .
4) The Steering Committee will assist in the development of a performance management strategy for all PPS Partners.
5) Payment Reform. The Steering Committee will provide feedback/advisory on payment reform and value based reimbursement.
6) Workforce Strategy. The Steering Committee will inform workforce discussion and review the workforce strategy on an ongoing basis.
7) Data Sharing and Confidentiality. The Steering Committee will advise on data sharing and confidentiality approach.
SI PPS, LLC's governance is further delegated to the Governance Committees based on their roles and functions. These committees will be comprised of PPS Partner representatives allowing the PPS Partners to maintain an active voice in SI PPS, LLC. The Governance

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Committees coordinate tasks and responsibilities thru the PMO to the respective project teams. The Governance Committees will make recommendation for approval to the Steering Committee and the Board. Summarized below are the key responsibilities of each of the Governance Committees:

• Finance Committee. This committee will oversee the financial management process, fund distribution, fund status monitoring, fund reporting, budget and financial compliance. Additionally, the Finance Committee will assess the financial impact of DSRIP on PPS Partners.
• Clinical Committee. This committee will be clinician led and will monitor clinical quality standards and measurements; oversee the clinical performance evaluation process; and ensure clinical performance for the PPS network. The committee will monitor PPS Partners' level of DSRIP clinical quality through a cycle of continuous performance improvement.
• Data/IT Committee. This committee will support the development of an appropriate IT platform to support the integration of the PPS Information Systems; develop data collection and retention policies, oversee data privacy and security; and monitor compliance with relevant regulations and laws. In addition, the committee will oversee HIE use, and RHIO interoperability.
• Workforce Committee. This committee will oversee healthcare staff and professional hiring, retention and redeployment within the PPS network.
• Compliance Committee. This committee will ensure the PPS Partners comply with all relevant DSRIP policies and protocols.
• Communication & Marketing Committee. This committee will oversee the internal communications within the SI PPS, LLC as well as external communications.
• Health Literacy & Cultural Competency Committee. This committee will oversee the development of programs to improve health literacy and cultural competency.

Members of the Governance Committees will be selected based on a set of defined criteria to ensure the members are representative of the full range of PPS Partners.

***Structure 3:**

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

The Clinical Governance is charged with oversight of clinical pathways and metrics. The Clinical Governance Committee shall establish the following processes:
1) Quality standards and metrics. SI PPS, LLC, with advisory services from the Steering Committee and the Clinical Committee will establish clear clinical quality standards and metrics. The role of the Clinical Committee is to assist in the management of the PPS network in meeting project requirements and ensure that PPS Partners are appropriately assessed for their quality of clinical care in meeting the PPS standards. The Clinical Committee and Steering Committee will work with the representatives from PPS Partners to determine a set of agreed upon standards and metrics. Such measures will include, but not limited to: Health outcomes; Clinical protocols and guidelines; Patient safety ; Use of health care resources; Patient engagement and Documentation of clinical records.
The Clinical Committee will monitor the adherence to these standards.
2) Clinical care management. A sound clinical care management process should comprise an appropriate IT system and appropriate workflows. The PPS will utilize multiple care management providers to deliver care management services to PPS patients. The Clinical Governance of the PPS in conjunction with the Data/IT Committee will work to ensure an IT system is in place to support the integration of data to allow for rapid cycle evaluation.
3) Accountability for realizing clinical outcomes and adherence to clinical protocols will be a responsibility of the Clinical Committee. The clinical governance structure will track and report on clinical outcomes based on established DSRIP clinical standards and metrics on an ongoing basis to the Board and Steering Committee. The Steering Committee and Clinical Committee will collaboratively work with a poor performing PPS Partner to identify the root cause and design a corrective action plan.

***Structure 4:**

Where applicable, outline how the organizational structure will evolve throughout the years of the DSRIP program period to enable the PPS to become a highly-performing organization.

The governance structure described above will provide a strong basis for the PPS to evolve towards an integrated delivery system. The operational and governance structure will evolve over time as the PPS gains more experience and grows as an organization and as

regulatory changes impact the PPS. With that expectation, the Steering Committee, along with the Board, will continue to monitor the progress and success of the PPS's performance and as appropriate formulate changes to the governance structure.

Section 2.2 - Governing Processes:

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

***Process 1:**
Please outline the members (or the type of members if position is vacant) of the governing body, as well as the roles and responsibilities of each member.

SIUH and RUMC will each appoint 5 managers to a 10 person Board. Under the Board, the Steering Committee will advise the Board on all matters relating to DSRIP projects and will handle daily PMO operations. This Committee will have at least 12 members, each representing the partners involved in the PPS. The Governance Committees described above will oversee their designated areas, advise the PMO as to their respective governed areas and regularly report to the Steering Committee and Board. The Project Advisory Committee will provide advice and consultation to the Governance Committees.

In addition to Committee members and the chairs of such committees, the Board will appoint senior officers to correspond with the Governance Committees and to provide regular reports of operations, financial performance, and compliance. Officers include a CEO, CFO, CIO, CMO, Chief Legal Officer, and Human Resources Vice Presidents. Specific members have not yet been identified.

***Process 2:**
Please provide a description of the process the PPS implemented to select the members of the governing body.

Under SI PPS, LLC's bylaws, directors are appointed by the two members of SI PPS, LLC: (i) SIUH; and (ii) RUMC. The directors are selected based on community commitment, experience in healthcare and their demonstrated leadership. The Board will consider, during the DSRIP planning phase, recommendations/feedback from the coalition partners. All recommendations from the PAC will be considered during the DSRIP implementation phase and the Board will rely on the Steering Committee in carrying out its workload.

The members to be selected on the Steering Committee will be based on a consideration of several key factors including: (1) the stakeholder's potential to contribute to the success of the projects selected under DSRIP, (2) attribution, (3) geography (physical location and communities served), (4) expertise, (5) resources committed to community outreach, and (6) relationships with candidate stakeholders. In addition, SI PPS, LLC has been holding informal meetings with potential stakeholders, including physicians, unions and community-based organizations, to obtain feedback about the composition of the Steering Committee leadership. Based on such analysis and feedback, the Board will identify the types of stakeholder positions to be included on the Steering Committee and will solicit nominations for each position from its partners. Each position on the Committee will be voted upon and nominees with the most votes for each position will be elected to that position.

To select the members of the PAC, the Board is undertaking a process similar to that of the Steering Committee. It will identify the types of stakeholders to be represented on the PAC with the goal of including as many stakeholder types as reasonably feasible. At a general stakeholder meeting held in July, feedback from the community was received and based on such feedback, SIUH and RUMC have identified types of stakeholder positions it believes will be included on the PAC. Population of the PAC will also involve a nomination of stakeholder best represented per stakeholder category and geographic area, based on experience and stakeholder affiliation and those receiving the most votes will be selected.

***Process 3:**
Please explain how the selected members provide sufficient representation with respect to all of the providers and community organizations included within the PPS network.

SIUH and RUMC, the only two acute care hospitals in Staten Island (SI) (PPS Co-Leads) have a history of providing a wide range of care to the Medicaid population, leadership experience in driving collaborative community initiatives, and existing relationships with providers and community organizations. Additionally, the SI PPS Steering Committee includes representatives from PPS partners, including mental health providers, primary care providers, federal qualified health centers, substance abuse providers, health home, home care agencies, and community based organizations. The Governance Committees will also contain representation from across the PPS provider network

and will be chosen based on criteria to ensure all providers are appropriately represented. The labor unions are represented in the PAC and the Workforce Committee. Community stakeholders will also sit on the PAC.

***Process 4:**

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

The PPS Co-Leads RUMC and SIUH have relied heavily on PPS partner engagement through a subcommittee structure with all PPS partners represented during the DSRIP planning process. PPS partners have supported the development of all components of the DSRIP application. As described above, PPS partners will continue to be represented on all governance committees included the Steering Committee and the Governance Committees. SIUH and RUMC's history of providing a wide range of care to the Medicaid population and experience driving collaborative community initiatives through relationships with community based organizations (CBOs) and providers strengthens the PPS' ability to manage a network of partners committed to transformation. The PPS will engage/contract with CBOs in order to implement DSRIP projects, including to assist in PAM activities through Project 11.

***Process 5:**

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

The decision making and voting process will be defined and documented in both SI PPS, LLC's operating agreement and in the Committee charters. At the Board level, decisions will be made by majority vote of the Board, which will include equal representation from SIUH and RUMC. A supermajority vote of the Board is required for decisions involving the sale of all/substantially all assets, bankruptcy or liquidation, approval of operating budgets, funds flow formulas and amendments thereto, amendment of the Operating Agreement or Certificate of Incorporation and matters affecting tax status.

At the Committee level, consisting of the Steering Committee and various Governance Committees, the below outlines the contemplated decision making and voting process:
1) Each committee member has one vote on all matters that come before the committee
2) Voting will be calculated based on the number of "yes" or "no" votes cast.
3) A quorum will be required (60% of committee membership in attendance) to ensure minimum attendance of committee members.
4) Decisions will be made upon an affirmative vote of a majority of the committee members present
5) The decisions are reported as recommendations to the Board for further approval by the Board
6) Committee minutes will outline all voting that resulted in favorable recommendations to the Board as well as matters that did not achieve an affirmative vote of a majority of committee members

***Process 6:**

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

The issue will be submitted to a governance committee (e.g., finance, IT, clinical, compliance, workforce committees) or Steering Committee, depending on the scope of the conflict, for resolution by an affirmative vote as noted immediately above. Where an affirmative vote in the majority cannot be achieved, the consensus is brought to the attention of the Board and reassessed by the SI PPS, LLC Executive Governance and Corporate Members. It is contemplated that approval by the Board will require the affirmative votes of managers representing each of SIUH and RUMC; given their equal representation on the Board and that a majority vote will be required for approval. In the absence of a majority of the managers approving the applicable proposed item, such item shall be considered disapproved.

***Process 7:**

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

Meetings will be open to all partners that are part of the PPS with meeting dates and locations available in advance on SI PPS, LLC's website. However, there may be closed sessions at these meetings, at the governing body's discretion, on any matter deemed confidential or proprietary. Meeting materials (excluding confidential or proprietary information) and all governance documents will be made available to partners upon request. Meeting materials posted on the website will exclude all confidential or proprietary information. In addition, the PPS' Communication & Marketing Committee will develop and implement policies and procedures related to the PPS' communications, which will include:

- Appointment/termination of committee members
- New/updated policies and procedures
- Change of organizational structures
- Performance evaluation outcomes
- Compliance monitor outcomes
- External/internal audit results
- Acceptance of new PPS members

***Process 8:**

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

SI PPS understands that transparency and communication are the key components for successful stakeholder engagement. Key stakeholders representing PPS partners, as well as union and other community representatives will be members of PPS governance committees.

To ensure further transparent engagement of stakeholders, including Medicaid members, information related to the following will be shared with community stakeholders, but not limited to:

- Appointment and termination of committee members
- New or updated policies and procedures
- Performance evaluation outcomes
- External and internal audit results
- Acceptance of new PPS member

The Communication & Marketing Committee will be responsible for the execution of key and critical topics related to stakeholder engagement over the life of the DSRIP program. Stakeholder engagement strategies may include, but will not be limited to: patient satisfaction surveys, PPS partner surveys, town hall meetings, a DSRIP website, etc.

Section 2.3 - Project Advisory Committee:

Description:

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

***Committee 1:**

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

The Staten Island PPS PAC was formed over the past few months (during the DSRIP planning process) and is comprised of representatives from more than 30 PPS Partners (includes representatives from mental health, substance abuse, nursing homes, and home care agencies), employee labor unions, and community interest organizations to achieve even representation of provider, employee, and beneficiary needs and to represent the interests of different subsets of collaborators. The labor unions, such as 1199 SEIU, New York State Nurses Association and the Federation of Nurses, and UFT represent the staff across multiple collaborator organizations. The PAC will meet monthly and/or as needed prior to DSRIP Year 1 and throughout the DSRIP implementation. Going forward the PAC's role will include advising the Workforce Committee on training and redeployment of existing staff as well as new hires.

***Committee 2:**

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

The PAC, reporting to the Steering Committee, will serve as an advisor and supporting body to the Board by obtaining feedback from PPS partners and stakeholders. The PAC will share such feedback with the Board and make recommendations based on such feedback. Accordingly, partner and stakeholder voices will be heard as an important part of the PPS' governance.

SI PPS, LLC will have relationships with CBOs and charitable organizations. SI PPS, LLC will enter into agreements with such

organizations to solidify an ongoing relationship in serving Medicaid patients through DSRIP projects overseen by the PAC. Examples of CBOs with which SI PPS, LLC will have a relationship include: Archdiocese Drug and Alcohol Prevention Program, Developmental Disabilities Services Council, Families on the Move, Funds, and Staten Island Child and Adolescent Mental Health Committee. The agreements with these organizations will emphasize a commitment to expanding services available to Medicaid population.

***Committee 3:**

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

Members of the PAC have participated throughout the DSRIP planning process including informing and providing ongoing guidance on the Community Needs Assessment (CNA), project development, as well as the PPS planning organizational structure (which informed the PPS organizational structure).

***Committee 4:**

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

The PAC includes human resource representatives from the key PPS provider network as well as Staten Island labor representatives. Representations from numerous provider organizations included in the PPS network are represented in the PAC including mental health and substance abuse providers, primary care providers, hospitals, skilled nursing facilities, homecare agencies, federally qualified health centers, and community based organizations, among others.

Section 2.4 – Compliance:

Description:

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

***Compliance 1:**

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

A Compliance Committee will be appointed by the Board. The Compliance Committee will recommend an individual to the Board to serve as the Compliance Officer ("CO"), who shall be employed by SI PPS, LLC. The CO shall have direct responsibility to report to the Board and will have direct access to the SI PPS, LLC CEO and the Board. The CO will attend all meetings of the Steering Committee and the Board as an ex-officio, non-voting member. The CO will be responsible for developing and implementing the compliance practices and serving as an organization-wide resource. The CO and members of SI PPS, LLC will be independent.

***Compliance 2:**

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

The CO and Compliance Committee will be responsible for the on-going review of PPS arrangements, policies and procedures, and the following compliance plan mechanisms will be established:

• Internal Risk Assessments: periodic established formal baseline assessments of each division, with compliance risks prioritized.
• Identified Performance Indicators (benchmarks): periodic assessment of compliance with applicable laws, regulations and policies.
• Ongoing Monitoring: continuous measurement of the effectiveness of management attainment of performance indicators at intervals with feedback to the Board.
• Corrective Action: follow-up and address identified risk issues.
• Focused and routine audits: scheduling of periodic audits and checks for incident reporting and regulatory concerns.

The CO and Compliance Committee will periodically report to the Board the results of its activities.

***Compliance 3:**

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

Employees, management, and staff of the partners currently receive compliance training under any existing compliance programs required or approved by state, federal, and accrediting agencies, currently maintained by the partners. In addition, all such individuals participating in this PPS will receive compliance training by SI PPS, LLC. By the second quarter of 2015, the general compliance program will be implemented and the CO is developing/approving both the general and specific education and training programs. General training will include:
- ACP's compliance philosophy and commitment to compliance.
- Code of Conduct and compliance expectations.
- Employee obligations to adhere to laws and regulations and consequences for non-compliance.
- Reporting standards and confidential reporting process.
- Identification of CO and overseers of compliance.

***Compliance 4:**

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

Every individual attributed to the PPS (or their representative) will receive written and web-based information concerning their rights to file complaints or register concerns about their health care providers. No provider or entity may retaliate against an individual for filing a complaint. The complaint may be registered:

• On-line at the PPS website or a Member's website
• By email
• At the PPS complaint hotline (to be provided)

Members and beneficiaries will be informed of the complaint process in the provider's notice of privacy practices and in materials available on-line and at the provider offices, which shall be available by the time the Compliance Plan is instituted.

Section 2.5 - PPS Financial Organizational Structure:

Description:

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

***Organization 1:**

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

SI PPS, LLC will be the initial recipient of all DSRIP funds paid to the PPS. RUMC and SIUH, the two members of SI PPS, LLC, will agree upon a formula pursuant to which all such funds will then be allocated among the two members according to a HUB methodology. For purposes of funds allocation and distribution, each of RUMC and SIUH shall be the "HUB Leader" of its own HUB. Each HUB Leader will then allocate their respective HUB's funds in accordance with an approved methodology for such HUB. The Finance Committee will assist in formulating the necessary methodologies for allocation among the HUBs and within the HUBs, with the methodology for allocating among the two HUBs to be approved by both SIUH and RUMC and for within each HUB to be approved by the respective HUB Leader for such HUB. The methodologies will be optimized to ensure that the right amount of funds are distributed to the appropriate PPS Partners on a timely basis. The Finance Committee will further assist in evaluating the PPS's overall performance with respect to all funding criteria established within the HUBs and established by the DSRIP program.

***Organization 2:**

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

Finance functions are assumed principally by the Finance Committee and the PPS' CFO. Key functions include:
- Establishing the annual operating and capital budgets
- Developing the formula for allocation for DSRIP funds among the HUBS and to all PPS partners
- Monitoring criteria for fund distribution

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- Defining metrics each partner is expected to achieve
- Defining criteria for the portion of DSRIP funds that are reserved for unforeseeable events.
- Establishing an independent audit process over fund distributions
- Developing internal controls over funds flow
- Developing procedures for handling complaints with distribution, account and audit from partners and stakeholders
- Monitoring spending commitments and financial risk
- Developing recommendation to Finance Committee and Board related to sustainability of PPS funding initiatives

***Organization 3:**

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

Each of the Governance Committees (e.g., IT, Compliance, Clinical, Finance) will employ internal auditors and supplement with an external audit function. In addition, each Committee is authorized to develop procedures for engaging independent auditors and to coordinate the audits.

Internal auditor duties include:
- Developing the internal audit plan
- Reviewing annual financial statements, compliance protocols, clinical and IT processes and respective internal communications.
- Auditing management's internal controls, compliance and risk assessment practices.
- Conducting special investigations (e.g., suspected corruption, conflicts of interest, criminal activity) and complaint processes.

Independent external auditors will be employed to further perform the following duties:
- Issue opinions on financial statements to evaluate financial or compliance trends over the year or longer.
- Evaluate performance of our auditor's internal quality control procedures.
- Evaluate the relationship between an internal auditor and the PPS.

***Organization 4:**

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

Each of the Governance Committees (e.g., IT, Compliance, Clinical, Finance) will employ internal auditors and supplement with an external audit function. In addition, each Committee is authorized to develop procedures for engaging independent auditors and to coordinate the audits.

Internal auditor duties include:
- Developing the internal audit plan
- Reviewing annual financial statements, compliance protocols, clinical and IT processes and respective internal communications.
- Auditing management's internal controls, compliance and risk assessment practices.
- Conducting special investigations (e.g., suspected corruption, conflicts of interest, criminal activity) and complaint processes.

Independent external auditors will be employed to further perform the following duties:
- Issue opinions on financial statements to evaluate financial or compliance trends over the year or longer.
- Evaluate performance of our auditor's internal quality control procedures.
- Evaluate the relationship between an internal auditor and the PPS.

Section 2.6 – Oversight:

Description:

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

***Oversight 1:**

Describe the process in which the PPS will monitor performance.

SI PPS's process to monitor performance of its PPS Partners includes, but is not limited to:
1) Clinical Committee: The Clinical Committee will review data regarding clinical performance and report to the Steering Committee
2) Finance Committee: The Financial Committee will review data regarding financial performance and report to the Steering Committee

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3) Steering Committee Monitoring and Reporting Duties. The Steering Committee will conduct ongoing oversight of the performance of PPS Partners and coalition partners and will report regularly on such matters to the Board (with input from the Clinical Committee and the Finance Committee). Metrics and Rating System. Performance evaluation metrics and rating systems will be established to assess PPS Partner performance. The metrics will be designed to measure PPS Partner performance based on the quality of patient care and adherence to PPS related policies and procedures.
4) Data Collection for Metrics. Data to be used for evaluation metrics will be collected qualitatively and quantitatively.
5) Monitor Cycle. The performance will be evaluated on a continuous basis.

***Oversight 2:**

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

The governing body (Clinical Committee, Steering Committee) responsible for performance monitoring will generate reports of partners or vendors who fail to meet the minimum standard set for applicable project metrics. The PPS will address such lower performing members with the following actions:
1) Corrective Action Plan. Members who require corrective action will be notified. The Steering Committee and Compliance Committee will collaboratively work with the poor performance member to identify the root causes for the poor performance and design a corrective action plan. The corrective action plan will be approved by the Steering Committee before it is implemented. The corrective action plan will consist of identifying specific areas of deficiency and thereafter providing needed education, training and detail oriented support to the provider. Ongoing training and support may be provided to the low performer to help achieve higher performance for a certain period of time.
2) Measurement of Corrective Action. On a monthly or quarterly basis, (or as needed) the results from the correction action plan will be evaluated using the performance metrics and rating system.

***Oversight 3:**

Describe the process for sanctioning or removing a poor performing member of the PPS network who fails to sufficiently remedy their poor performance. Please ensure the methodology proposed for member removal is consistent and compliant with the standard terms and conditions of the waiver.

In the event that a low-performing PPS Partner, despite the interventional actions described above, continues to perform poorly after an agreed upon timeframe, low performers will be monitored more frequently and receive timely assessments. If improvement is not shown after 30 days, the partner will be called before the Board who will take into account feedback provided by Medicaid beneficiaries. The Board may implement systematic sanctions which can range from monetary withhold for further training and support to partner dismissal from the PPS. CAP and sanctions will have been exhausted before the Board considers dismissal. If these measures fail to produce a satisfactory turnaround with respect to the low-performing PPS Partner, the Board may prepare a Statement of Recommendation to Dismiss to be presented to a combined meeting of [the PPS Partner, the Board, and the Steering Committee). The PPS values DSRIP and its partners, and will not take lightly the removal of any of its partners, striving to promote success of each partner and of the PPS as a whole.
SI PPS recognizes that the DSRIP programs spans five years and impacts of DSRIP will extend well beyond that time. From that recognition SI PPS will establish a process to add additional partners. Any organization seeking to join, or re-join

***Oversight 4:**

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

Performance of PPS providers will be monitored through internal feedback from Medicaid beneficiaries and advocates, and also from:
- On-line at the SI PPS, LLC website or a Member's website.
- By mail at SI PPS, LLC's risk management office (address to be determined).
- By facsimile at a list of numbers to be provided.
- At the SI PPS, LLC complaint hotline at 1-800-xxx-xxxx where they may speak to a SI PPS, LLC representative.
- Designated patient representatives or offices at each of the partners of SI PPS, LLC (contacts to be determined).

In addition, the Board will take into account Medicaid beneficiary feedback when evaluating a low performer or poorly performing provider. The Board will monitor more frequently and may implement a corrective action plan and/or systematic sanctions ranging from withholding DSRIP funds due, to dismissal from the PPS.

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***Oversight 5:**

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

Medicaid beneficiaries and their advocates will be notified of providers that are removed from the PPS. The Communication Committee will develop a comprehensive approach to communicate these changes to ensure Medicaid members are notified in a timely manner to ensure the continuity of care for impacted patients including the use of the DSRIP website, mailings, among other.

Section 2.7 - Domain 1 – Governance Milestones:

Description:

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

- Implementation plan outlining the PPS' commitment to achieving its proposed governance structure (Due March 1, 2015).
- Periodic reports, at a minimum semi-annually and available to PPS members and the community, providing progress updates on PPS and DSRIP governance structure.
- Supporting documentation to validate and verify progress reported on governance, such as copies of PPS bylaws or other policies and procedures documenting the formal development of governance processes or other documentation requested by the Independent Assessor.

☑ Please Check here to acknowledge the milestones information above

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SECTION 3 – COMMUNITY NEEDS ASSESSMENT:

Section 3.0 – Community Needs Assessment:

Description:
All successful DSRIP projects will be derived from a comprehensive community needs assessment (CNA). The CNA should be a comprehensive assessment of the demographics and health needs of the population to be served and the health care resources and community based service resources currently available in the service area. The CNA will be evaluated based upon the PPS' comprehensive and data-driven understanding of the community it intends to serve. Please note, the PPS will need to reference in Section 4, DSRIP Projects, how the results of the CNA informed the selection of a particular DSRIP project. The CNA shall be properly researched and sourced, shall effectively engage stakeholders in its formation, and identify current community resources, including community based organizations, as well as existing assets that will be enhanced as a result of the PPS. Lastly, the CNA should include documentation, as necessary, to support the PPS' community engagement methodology, outreach and decision-making process.

Health data will be required to further understand the complexity of the health care delivery system and how it is currently functioning. The data collected during the CNA should enable the evaluator to understand the community the PPS seeks to serve, how the health care delivery system functions and the key populations to be served. The CNA must include the appropriate data that will support the CNA conclusions that drive the overall PPS strategy. Data provided to support the CNA must be valid, reliable and reproducible. In addition, the data collection methodology presented to conduct this assessment should take into consideration that future community assessments will be required.

The Office of Public Health (OPH) has listed numerous specific resources in the CNA Guidance Document that may be used as reference material for the community assessment. In particular, OPH has prepared a series of Data Workbooks as a resource to DSRIP applicants in preparing their grant applications. The source of this data is the Salient NYS Medicaid System used by DOH for Medicaid management. The PPS should utilize these Workbooks to better understand who the key Medicaid providers are in each region to assist with network formation and a rough proxy for Medicaid volume for DSRIP valuation purposes. There will be three sets of workbooks available to the PPS, which will include:

Workbook 1 - Inpatient, Clinic, Emergency Room and Practitioner services
Workbook 2 - Behavioral Health services
Workbook 3 - Long Term Care services

Additionally, the New York State Prevention Agenda Dashboard is an interactive visual presentation of the Prevention Agenda tracking indicator data at state and county levels. It serves as a key source for monitoring progress that communities around the state have made with regard to meeting the Prevention Agenda 2017 objectives. The state dashboard homepage displays a quick view of the most current data for New York State and the Prevention Agenda 2017 objectives for approximately 100 tracking indicators. The most current data are compared to data from previous time periods to assess the annual progress for each indicator. Historical (trend) data can be easily accessed and county data (maps and bar charts) are also available for each Prevention Agenda tracking indicator. Each county in the state has its own dashboard. The county dashboard homepage includes the most current data available for 68 tracking indicators.

Guidance for Conducting Community Needs Assessment Required for DSRIP Planning Grants and Final Project Plan Applications
http://www.health.ny.gov/health_care/medicaid/redesign/docs/community_needs_assessment_guidance.pdf

In addition, please refer to the DSRIP Population Health Assessment Webinars, Part 1 and 2, located on the DSRIP Community Needs Assessment page
http://www.health.ny.gov/health_care/medicaid/redesign/dsrip_community_needs_assessment.htm

This section is broken into the following subsections:

- 3.1 Overview on the Completion of the CNA
- 3.2 Healthcare Provider Infrastructure
- 3.3 Community Resources Supporting PPS Approach
- 3.4 Community Demographics
- 3.5 Community Population Health & Identified Health Challenges

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3.6 Healthcare Provider and Community Resources Identified Gaps
3.7 Stakeholder & Community Engagement
3.8 Summary of CNA Findings.

Scoring Process:

This section is worth 25% of the total points available for the Overall PPS Structure Score. The responses will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.

3.1 is worth 5% of the total points available for Section 3.
3.2 is worth 15% of the total points available for Section 3.
3.3 is worth 10% of the total points available for Section 3.
3.4 is worth 15% of the total points available for Section 3.
3.5 is worth 15% of the total points available for Section 3.
3.6 is worth 15% of the total points available for Section 3.
3.7 is worth 5% of the total points available for Section 3.
3.8 is worth 20% of the total points available for Section 3.

Section 3.1 – Overview on the Completion of the CNA:

Description:
Please describe the completion of the CNA process and include in the response the following:

***Overview 1:**
Describe the process and methodology used to complete the CNA.

A comprehensive CNA was conducted September-December 2014. The Staten Island PPS, under the co-leadership of Staten Island University Hospital and Richmond University Medical Center, conducted the assessment following the NYSDOH Guidance for Conducting Community Needs Assessment. BDO Consulting LLC, who was hired by the PPS to assist with DSRIP application development, provided support during the process. Data was assessed to identify health issues that needed to be addressed to achieve DSRIP goals.

A critical part of the CNA was stakeholder/community engagement. Primary data was collected via a PPS partner survey, a community survey, 4 community focus groups (community, behavioral health, & nursing home focus groups), and PPS steering and subcommittee meetings. The PPS survey was distributed to all PPS partners to assess the network's resources/capabilities. The community survey, developed by the PPS, was distributed to 1,000+ Staten Island residents. It assessed respondents' demographics/economic factors, care utilization, health status, and healthcare satisfaction. Focus groups and PPS steering/subcommittee meetings were used as forums to discuss the care environment from the prospective of the community members and the PPS.

Other data was obtained from publically available demographic/health data. Internal PPS partner (hospital, nursing home, home health, FQHC, physician, behavioral health, and managed care) utilization data was assessed.
A comprehensive CNA was produced that illustrated the following for the Staten Island Medicaid/uninsured: demographic profile, disease prevalence & critical health status indicators, inpatient/ED utilization, the health/social service/community provider infrastructure, the community's perspective of the services/resources that impact health, and the gaps, challenges, and opportunities for care transformation. The CNA was shared publically with the community and PPS partners at focus group and PPS meetings.

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

Primary data was collected via a 47-question PPS partner survey, 37-question multilingual community CNA survey, 4 community focus groups (community, behavioral health, & nursing home groups ranging 6-33 attendees), and 3 PPS steering committee & 15 PPS subcommittee meetings. PPS survey was distributed to all PPS partners to assess network's resources/capabilities. Community survey, developed by the PPS, was distributed to 1,000+ patients/clients at 18 organizations/locations on Staten Island including hospitals, behavioral health providers, skilled nursing facilities, primary care providers, clinics, health home, food pantries, and community/faith-based organizations. 1,015 surveys were completed. The community survey assessed respondents' demographics, education level, domestic/social circumstances, insurance status, care utilization, health status, and healthcare satisfaction. Focus groups and PPS steering/subcommittee meetings were used as forums to discuss the Staten Island healthcare environment (current resources/gaps) from the prospective of the community members and PPS partners.

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Other data used in the analysis was obtained from publically available demographic/health data. US Census, American Community Survey, New York State Department of Health and New York City Department of Health and Mental Hygiene data (including Epiquery statistics), New York State Department of Health Statewide Planning and Research Cooperative System (SPARCS), Salient New York State Medicaid Claims Database, American Medical Association, Center for Health Workforce Studies' New York State Health Workforce Planning Data, Greater New York Hospital Association Health Information Tool for Empowerment (HITE), and Staten Islander provider websites were used.

Internal PPS partner (hospital, nursing home, home health, FQHC, behavioral health, physician, & managed care) data was assessed.

CNA findings validated PPS project selection proposed in the DSRIP Application.

Section 3.2 – Healthcare Provider Infrastructure:

Description:
Each PPS should do a complete assessment of the health care resources that are available within its service area, whether they are part of the PPS or not. For each of these providers, there should be an assessment of capacity, service area, Medicaid status, as well as any particular areas of expertise.

***Infrastructure 1:**
Please describe at an aggregate level existing healthcare infrastructure and environment, including the number and types of healthcare providers available to the PPS to serve the needs of the community. Please provide a count both of the resources in the community in general, as well as resources that are part of the PPS Network. Use the table below. Add rows for additional Provider Types.

#	Provider Type	Number of Providers (Community)	Number of Providers (PPS Network)
1	Hospitals	2	2
2	Ambulatory surgical centers	2	2
3	Urgent care centers	8	2
4	Health Homes	1	1
5	Federally qualified health centers	3	2
6	Primary care providers including private, clinics, hospital based including residency programs	494	133
7	Specialty medical providers including private, clinics, hospital based including residency programs	806	435
8	Dental providers including public and private	370	37
9	Rehabilitative services including physical therapy, occupational therapy, and speech therapy, inpatient and community based	1184	100
10	Behavioral health resources (including future 1915i providers)	27	13
11	Specialty medical programs such as eating disorders program, autism spectrum early	1	1
12	diagnosis/early intervention	26	3
13	Skilled nursing homes, assisted living facilities	16	11
14	Home care services	21	7
15	Laboratory and radiology services including home care and community access	43	18
16	Specialty developmental disability services	8	4
17	Specialty services providers such as vision care and DME	85	0
18	Pharmacies	52	0
19	Local Health Departments	1	1
20	Managed care organizations	58	3
21	Foster Children Agencies	4	0
22	Area Health Education Centers (AHECs)	1	0

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

***Infrastructure 2:**

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

Regardless of location in Staten Island, providers serve the entire Island. Historical data shows very little care outmigration to other New York City (NYC) areas. However, in order to advance DSRIP goals, the following needs to be addressed:

Staten Island supply of primary care providers, specialists, and behavioral health & social worker providers is low relative to NYC and State rates (this trend is similar to the bed count trend; Staten Island has significantly lower beds per 100,000 residents compared to NYC and State rates, which impacts capacity). Historically, the ability to recruit physicians to establish practices in the borough has been problematic. Additional primary care providers, psychiatrists, physician extenders (nurse practitioners), and care managers/health coaches are needed to impact health.

With no Health and Hospitals Corporation acute care facility on the Island, Staten Island University Hospital and Richmond University Medical Center are the only acute care safety-net providers in the community that provide comprehensive inpatient care, hospital-based outpatient care, and community health education/outreach to vulnerable populations. There are 3 FQHCs currently, and 2 more sites are planned (independent of DSRIP). More community care needs to be developed, and these resources need to target the high health need areas of Staten Island's North Shore ("hot spots"). Mobile health resources, new disease management programs, and IT systems enabling telehealth will aid in providing access in the community education/outreach. These resources would also help with reaching patients throughout the Island. Currently, physician practices cluster around the hospital campuses located in the North Shore.

FQHCs and other ambulatory providers such as physicians need to offer extended hours during the week/weekends. Patients/providers recognize that limited practice hours negatively impact ED utilization. Patient can't access appropriate care due to long appointment wait times and limited hours.

Behavioral health and primary/medical care needs to be co-located or rapid referral to behavioral health/medical care needs to be implemented to best serve the community. Providers identify that this change in care delivery would be key to managing readmissions, decreasing avoidable utilization, and improving clinical care/outcomes.

Increasing ambulatory detox services is key as there is a lack of ambulatory detox capacity.

Cultural/health literacy barriers exist for patients with chronic diseases that impact the ability to manage health and for patients /families with regard to perception of palliative care.

Although Island providers have a strong history of collaboration, communication of information and care coordination among providers needs to improve. Communication issues between hospitals, private practice providers, nursing homes, and home health agencies impact avoidable hospital admissions. Best practice protocols and process standardization in care transition and care management need to be implemented across sites. Health information exchange should be developed to improve the health infrastructure.

Section 3.3 - Community Resources Supporting PPS Approach:

Description:

Community based resources take many forms. This wide spectrum will include those that provide services to support basic life needs to fragile populations as well as those specialty services such as educational services for high risk children. There is literature that supports the role of these agencies in stabilizing and improving the health of fragile populations. Please describe at an aggregate level the existing community resources, including the number and types of resources available to serve the needs of the community.

***Resources 1:**

Please provide a count both of the resources in the community in general, as well as resources that are part of the PPS Network. Use the table below. Add rows for additional Resource Types.

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

DSRIP PPS Organizational Application

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#	Resource Type	Number of Resources (Community)	Number of Resources (PPS Network)
1	Housing services for the homeless population including advocacy groups as well as housing providers	5	3
2	Food banks, community gardens, farmer's markets	6	3
3	Clothing, furniture banks	1	1
4	Specialty educational programs for special needs children (children with intellectual or developmental disabilities or behavioral challenges)	3	2
5	Community outreach agencies	0	0
6	Transportation services	4	0
7	Religious service organizations	181	0
8	Not for profit health and welfare agencies	21	8
9	Specialty community-based and clinical services for individuals with intellectual or developmental disabilities	15	7
10	Peer and Family Mental Health Advocacy Organizations	20	9
11	Self-advocacy and family support organizations and programs for individuals with disabilities	28	5
12	Youth development programs	8	2
13	Libraries with open access computers	13	0
14	Community service organizations	55	8
15	Education	18	4
16	Local public health programs	28	6
17	Local governmental social service programs	7	1
18	Community based health education programs including for health professions/students	20	6
19	Family Support and training	28	5
20	NAMI	2	0
21	Individual Employment Support Services	10	3
22	Peer Supports (Recovery Coaches)	1	0
23	Alternatives to Incarceration	1	1
24	Ryan White Programs	3	3
25	HIV Prevention/Outreach and Social Service Programs	4	2

***Resources 2:**

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

In terms of key community resource gaps, the availability of Staten Island community-based transportation support services is an issue. This is problematic because there is no MTA subway line on Staten Island unlike other New York City (NYC) boroughs, and only limited light rail service exists. Medicaid will provide subway metro cards, but will not reimburse for alternate forms of transportation needed on such as taxis. Patients have to rely on bus routes or the ability to access a personal vehicle. Patients have expressed their frustration in the ability to travel to doctor's offices for regular and follow-up appoints. Community organizations can help to address these issues by offering more transportation support services.

Overall, patients and providers have voiced concerns that more needs to be done to engage the population and inform them of the current resources present on the Island. More focused community outreach is needed. Community organizations can assist with funneling information to vulnerable populations who have chronic illness or behavioral health conditions, have been recently discharged from a hospital or skilled nursing facility, or who have rarely visited a healthcare provider for service. Additionally, community organizations can help to improve the health literacy of the population. Community organizations can also help serve as access points for preventive care such as screenings. Expanding the role/scope of existing community resources is critical in the effort to manage population health.

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IT systems can also be leveraged to help strengthen the ability of community organizations to collaborate with providers to engage the community. Community members need to be aware of all health and social service resources available to improve the health. Community organizations can leverage their strengths of being local "neighbors" who see their clients on a regular basis to inform and educate the public.

In general, as the uninsured, non-utilizers, and the low-utilizers are engaged, community organizations will have to reevaluate their capacity to serve the community. Health education, transportation services, family support services, and other community resources will have to expand to support the populations.

Section 3.4 – Community Demographic:

Description:
Demographic data is important to understanding the full array of factors contributing to disease and health. Please provide detailed demographic information, including:

***Demographics 1:**
Age statistics of the population:

Richmond County, the borough of Staten Island, is comprised of approximately 468,730 residents as of the 2010 US Census. Approximately 135,000 (roughly 30%) are unique Medicaid enrollees based on 2013 Salient NYS Medicaid claims data. Over 50% of Staten Island Medicaid beneficiaries live in the Island's North Shore communities (Stapleton, St George, Rosebank, Mariners Harbor, West New Brighton, and Port Richmond) based on claims data.

For the general Staten Island population, 13% of the total population is 65+ years old, 28% is 45-64 years old, 36% if 18-44 years old, and 23% is 00-17 years old (US Census).

For the Medicaid enrollee population, 16% are 60+ years of age, 84% are under 60, and roughly half of the total SI Medicaid enrollee population is 20-59 years of age. One of the largest sub-populations of Staten Island Medicaid enrollees is the white population 18-44 years old.

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

Staten Island overall is 64% White, 17% Hispanic, 10% Black, 7% Asian, and 2% all other races/ethnicities (2010 US Census). Medicaid enrollee population is 37.6% White, 26.5% Hispanic, 15.7% Black, 8.7% Asian, and 11.4% all other races/ethnicities (Salient NY Medicaid data). A majority of Hispanic & Black enrollees reside in the North Shore (Salient NY Medicaid data), a historically high health need area.

Communication barriers affect residents who are not proficient in English by limiting the quality of health information exchanged. 2012 American Community Survey data shows that older residents who speak English and another language compared to younger multilingual residents have more issues with English proficiency. This trend can be seen across different foreign language speaking groups. For example, 15% or less of the 5-17 age cohort (across language groups) are not proficient in English versus 40-60% of the 65+ cohort (across language groups) are not proficient in English

***Demographics 3:**
Income levels:

Compared to New York State, Staten Island is a relatively affluent, middle-class area with higher average household income statistics ($88,221 for Staten Island; $82,698 for New York State) and lower estimated poverty levels (13.7% for Staten Island; 14.5% for New York State). In regards to median household income statistics, median household income for Staten Island is $72,752 and New York State is $56,951. The home ownership rate is 69.8%, which is higher than the New York State average of 54.8%. (2010 US Census)

***Demographics 4:**
Poverty levels:

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The estimated poverty level for Staten Island is 13.7%, which is lower than the New York State average of 14.5%. (2010 US Census)

***Demographics 5:**

Disability levels:

Data from the 2012 American Community Survey was reviewed to understand the Staten Island disabled population and their ability to access healthcare resources. Overall, when looking at disability status, individuals with disabilities are able to access health insurance through either private or public health insurance. There are very low reported rates of no insurance coverage based on American Community Survey statistics.

***Demographics 6:**

Education levels:

Data from the 2012 American Community Survey was reviewed to understand the Staten Island population's education and insurance status, as it relates to one's ability to access healthcare resources. Staten Island residents between the ages of 25-64 with a bachelor degree or some college or high school education are more likely to have private insurance versus public insurance or no insurance. Staten Island residents who have less than a high school degree are more likely to have no health insurance or public coverage.

***Demographics 7:**

Employment levels:

2012 American Community Survey data was reviewed to understand the Staten Island community's employment and insurance status profile. Residents with public health insurance are more likely to be "not in the labor force" (not actively job seeking) compared to being employed or unemployed. Conversely, residents with no health insurance are more likely to be employed versus being unemployed or not in the labor force.

***Demographics 8:**

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

According to New York City Department of Correction, Staten Island is the only borough without a major detention center. Arthur Kill Correctional Facility, which was the only correctional facility on Staten Island, closed in 2011. Therefore, there is no demographic information on those who are institutionalized or involved in the criminal justice system on Staten Island.

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

As necessary, please include relevant attachments supporting the findings.

File Name	Upload Date	Description
43_SEC034_Final_Community Health Needs Assessment Staten Island_Databook 12 22 14.pdf	12/22/2014 03:51:46 PM	Staten Island PPS CNA Databook excludes community and PPS survey results.

Section 3.5 - Community Population Health & Identified Health Challenges:

Description:

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

***Challenges 1:**

Leading causes of death and premature death by demographic groups:

Publically available New York City mortality data were reviewed to asses leading causes of death. Staten Island has high household income and privately insured rates yet continues to be the borough with the highest rate of mortality (679.8 per 100,000 compared to a citywide aggregate of 622.7 per 100,000). The leading causes of death on Staten Island are cardiac disease and cancer with rates of 266.1 and 163.9 respectively, compared to NYC rates of 203.7 for cardiac disease and 151.3 for cancer. Other diseases where Staten Island has higher rates compared to NYC is lower respiratory disease, diabetes, and liver cirrhosis. The need for enhanced access to

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chronic disease management services can be argued, despite Staten Island's relative economic affluence.

Further, New York City data estimates that approximately 70% of non-Hispanic blacks are identified as being likely to die prematurely (before the age of 75) compared to the White population at roughly 40%. Among Staten Island's Hispanic population, approximately 60% of deaths are considered premature. Cancer and heart disease are the leading causes of premature death.

***Challenges 2:**

Leading causes of hospitalization and preventable hospitalizations by demographic groupings:

2012 Medicaid Preventive Quality Indicators (PQIs) identify Asthma/COPD (453 PQI hospitalizations), Diabetes (228), and Bacterial Pneumonia (177) as the leading causes of PQI hospitalizations, which can be considered preventable. Health Data NY shows that Staten Island's African American population is 3 times more likely to be hospitalized for asthma and twice as likely to be hospitalized for diabetes in comparison to the White population.

Salient New York Medicaid claims data was assessed. Behavioral health is a leading diagnosis for inpatient admission with over 2,200 unique Medicaid enrollees having a primary diagnosis of behavioral health (substance abuse and mental health). Cancer, diabetes, heart disease, heart failure, kidney disease, and asthma as are also problematic.

According to data provided by the 10 PPS skilled nursing facilities, Medicaid patients have estimated 1,500 annual transfers from nursing homes to hospitals. The top reasons for transfers: respiratory distress/shortness of breath, altered mental status, gastro-intestinal, cardiac (low blood pressure, heart failure, chest pain), sepsis, pneumonia, renal failure, and cerebrovascular complications.

***Challenges 3:**

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

2012 New York State Preventive Quality Indicators (PQI) were assessed for the Staten Island Medicaid population. PQIs are measures that can be used with inpatient discharges to identify care effectiveness. PQIs are conditions for which community/ambulatory care can potentially prevent the need for hospitalization or for which early ambulatory intervention can prevent complications/more severe disease.

Majority of ambulatory sensitive Medicaid PQI admissions for Island residents are for COPD/Asthma with 453 hospitalizations, Diabetes had 228 hospitalizations, Bacterial Pneumonia had 177 hospitalizations, and Heart Failure had 170 hospitalizations.

NYC Epiquery data states that 36.2% of Island residents ages 45-64 have a body mass index greater than 30, which is considered obese. 34.8% of residents ages 25-44 are obese. 64.6% and 39.5% of "Other" and Black races respectively have the highest percentages of obese residents. Epiquery identifies Staten Island as the borough with the highest percentage of current smokers at 16.5%. Smoking and obesity are known risk factors that impact health. These high rates impact the prevalence of ambulatory sensitive chronic conditions.

***Challenges 4:**

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

2012 New York Health Data Medicaid PQI rates (per 100,000 residents) were assessed for the 3 Staten Island regions (North Shore, Mid-Island, & South Shore).

For hypertension, almost all the communities in Staten Island had Medicaid PQI rates higher than the State average. For example, Mariners Harbor, St. George, New Dorp, and Eltingville communities are higher with 311.04, 180.26, 136.30, and 156.49, respectively, per 100,000 residents compared to the State's rate of 101.70 per 100,000.

For diabetes, the North Shore is the hot spot or high health need area with all 6 North Shore communities having higher PQI Medicaid rates compared to State rate of 311.91 per 100,000 residents. The highest rate of diabetes PQIs, 626.78/100,000, is from West New Brighton in the North Shore. Additionally, based on SPARCS 2013 data, there were over 4,000 inpatient discharges of Medicaid beneficiaries with a secondary diagnosis of diabetes. Both the Medicaid PQI and SPARCS Medicaid inpatient data illustrate the impact of diabetes in Staten Island.

The highest rate of Asthma/COPD PQI discharges, 2,097.97/100,000, is in the North Shore's Port Richmond community and is more than

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double the NYS rate of 913.95/100,000. St. George, New Dorp, Mariners Harbor, Rosebank, Stapleton, West New Brighton, and Eltingville are also communities that have rates over 1,000 per 100,000 residents, which is well above the State.

Based on NYS Cancer Registry data, expected incidence rates compared to observed rates for Colorectal, Female Breast, Prostate, or Lung cancer for Staten Island residents are largely within the 14.9% or less expected range.

For behavioral health conditions, 2013 Salient New York Medicaid claims data shows that more than 22,000 Staten Island Medicaid recipients of care (any type of care) had a primary behavioral health diagnosis (mental health and substance abuse), and almost 29,000 had a diagnosis of behavioral health (any level diagnosis: primary, secondary, etc.).

For diabetes, 2013 Salient New York Medicaid claims data shows that more than 9,500 Staten Island Medicaid recipients of care (any type of care) had a primary diabetes diagnosis, and about 14,000 had a diagnosis of diabetes (any level diagnosis: primary, secondary, etc.).

Overall, the North Shore is considered Staten Island's high health need area or "hot spot" in terms of disease prevalence for the Medicaid population.

***Challenges 5:**

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

Women in the North Shore of Staten Island are within the borough's highest quartile for not obtaining timely pre-natal care and having babies with low birth rates. High infant and neonatal mortality rates on Staten Island's North Shore highlight the need for additional targeted women's health and prenatal care for residents.

The rate for Staten Island women receiving late or no prenatal care is 3.5% compared to the NYC rate of 6.9%. The rate of Staten Island women having babies with low birth weight is 8.3% compared to 8.6% for NYC. The teenage pregnancy rate on Staten Island is 36.3 per 1,000 births compared to the NYC rate of 59.1.

The infant death rate on Staten Island is slightly higher than the NYC rate. On Staten Island, the infant death rate per 1,000 births is 4.7 compared to 4.3 in NYC.

(Source: Health Data NY).

***Challenges 6:**

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

NYC DOHMH Epiquery statistics state that 36.2% of Staten Island residents who are between the ages of 45 and 64 years old have a body mass index greater than 30, which is considered obese. 34.8% of residents who are between the ages of 25 and 44 years old are identified as being obese. 64.6% and 39.5% of "Other" and Black races respectively have the highest percentages of obese residents.

Epiquery statistics identify Staten Island as the borough with the highest percentage of current smokers at 16.5%. Estimates may be lower than actual rates due to high confidence intervals inherent to the statistical sampling methodology used by New York City Department of Health and Mental Hygiene.

The number and rate of unintentional drug poisoning/overdose deaths on Staten Island rose from 12.2 in 2010 to 19.9 in 2012 (rates per 100,000 per year). In 2011, the rate of opioid analgesic overdose deaths were four times higher than Manhattan's rate (2.3/100,000) and Brooklyn's rate (2.5/100,000).

***Challenges 7:**

Any other challenges:

Community survey was distributed to 1,000+ Staten Island residents as part of the Staten Island PPS Community Needs Assessment. 1,015 surveys were completed to identify health issues. The majority reported being enrolled in Medicaid (52.6%) and 19.2% described themselves as being Dual Eligible. Only 3.5% described themselves as being uninsured.

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4 most commonly occurring zip codes were from Staten Island's North Shore & Mid-Island regions. Age distribution was fairly evenly spread among 18-75+, and respondents described themselves as being White (62.5%), followed by Black (17.4%). Of those surveyed, 19.9% described themselves as being of Hispanic/Latino.

Survey respondents reported high blood pressure (32.7%), mental health (30.2%), depression (22.6%), asthma (22.8%), diabetes (18.4%), and substance abuse (18.0%) as being the most common conditions. High blood pressure, mental health, asthma, and depression were leading health conditions for receiving care.

Most common "access to care" issues were related to not having insurance and waiting too long to get an appointment.

Data highlights the challenges the community faces in terms of disease prevalence and access to care.

Section 3.6 – Healthcare Provider and Community Resources Identified Gaps:

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

***Gaps 1:**
Identify the health and behavioral health service gaps and/or excess capacity that exist in the community, **specifically outlining excess hospital and nursing home beds**.

There are 2 hospitals on the Island; both are private not-for-profit, acute care hospitals. Staten Island University Hospital is a 714-bed tertiary teaching hospital with 2 campuses in the North and South Shore. Richmond University Medical Center is a 473-bed acute care hospital with 2 campuses both on the North Shore. There are no Health and Hospitals Corporation acute care hospitals in Staten Island. In terms of bed capacity, Staten Island reports having a lower number of inpatient beds per 100,000 residents (264.2 per 100,000) compared to both NYC (305) and NYS (289) rates. Additionally, Staten Island has 269.2 physicians per 100,000 residents as compared to NYC (405) and NYS (348) residents, and 102.2 primary care physicians per 100,000 residents as compared to NYC (134.0) and NYS (120) rates. Bed and physician provider capacity is lower on Staten Island compared to NYC and the State.

According to the NYS Department of Health, Staten Island has 10 licensed skilled nursing facilities located in the North Shore/Mid-Island regions. The total number of beds reported equates to a higher bed rate per 100,000 than both NYC and NYS rates. The Island's care infrastructure is known for its skilled nursing facility services, due to the amount of beds available, and skilled nursing facilities have indicated that they have capacity to expand.

Staten Island has several licensed Office of Mental Health providers including the hospitals which provide inpatient services, outpatient assessment and treatment, and therapy and medication management. There are several Office of Alcoholism and Substance Abuse Services licensed providers located throughout Staten Island's three regions. The providers offer an extensive range of services including drug and alcohol outpatient treatment, outpatient intensive treatment, outpatient day rehab with alternative schooling, medication assisted treatment, opioid treatment, residential treatment, harm reduction, and inpatient detox and rehab. Despite the range of behavioral health services provided, Staten typically has a lower rate of mental health counselors, psychiatrists, and social workers in comparison to NYC and NYS. Due to the extensive services offered and generally low staffing rates as well as number of facilities, providers indicate that capacity/infrastructure will be an issue for providing expanded services under the DSRIP projects. Moreover, increasing ambulatory detox services is key as there is a lack of ambulatory detox capacity.

PQI analysis by disease show that the high health need Medicaid population is located primarily in the North Shore region. These "hot spots" highlight the North Shore as having the greatest need for quality care. Communication of information and care coordination among providers needs to improve. Communication issues between hospitals, private practice providers, nursing homes, and home health agencies impact avoidable hospital admissions. Best practice protocols and process standardization in care transition and management need to be implemented across sites. Health information exchange should be developed to improve the health infrastructure

***Gaps 2:**
Include data supporting the causes for the identified gaps, such as the availability, accessibility, affordability, acceptability and quality of health services and what issues may influence utilization of services, such as hours of operation and transportation, which are contributing to the

identified needs of the community.

There is a history of provider collaboration in Staten Island, but there is a need to improve care coordination and communication among providers and address critical barriers. These issues negatively impact the Medicaid population's ability to appropriately utilize care. In addition to the previously mentioned health statistics, PPS partner surveys, community surveys, focus groups, and PPS committee meetings identified the following issues.

Staten Island lacks MTA subway lines, creating access issues. Staten Island is the only borough without a subway, and the majority of the population accesses care via car/public bus. These transportation barriers impact patients' ability to travel as needed for regular/follow-up care.

Staten Island also lacks adequate provider staffing to effectively reach and care for at-risk populations and could benefit from additional primary care providers, health coaches, care managers, etc. to progressively monitor/impact patients' health.

Identified service needs to address gaps, including medication management and enhanced home care, are needed to avoid readmissions.

Behavioral health and primary care providers identified the need for the co-location of behavioral health and primary care to effectively manage the populations' health.

A lack of community resources including wellness and transportation services impacts patient access to care.

Provider operating hours create service gaps. The hospitals, EDs, and skilled nursing facilities are 24/7 operations. The FQHCs, urgent care centers, imaging facilities, physician practices, and other ambulatory providers offer some extended hours. Providers and community members cite that operating hours negatively impact the appropriate utilization of services, specifically ED care.

A lack of IT integration presents gaps in the quality of services offered, including care management and telehealth. Providers are unable to share health data, complete population-wide analytics, identify and track at-risk patients, and perform root cause analysis to improve service quality.

Further, Staten Island is comprised of an ethnically diverse population, presenting linguistic/cultural gaps for patients attempting to access and navigate services. Further, due to a lack of outreach staff and patient education, residents do not always know how to access healthcare resources.

***Gaps 3:**

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

As part of DSRIP project plans, Staten Island PPS has developed strategies including expanding services, leveraging existing programs, and providing training and certification to address identified gaps.

Addressing accessibility issues related to transportation, the PPS plans to expand upon existing mobile health program models to deliver preventative care services such as flu shots and health screenings in identified community "hot spots" such as faith-based organizations and community-based organizations in the North Shore.

To effectively impact patients' health and increase access to primary care and patient education, the PPS will expand upon current staffing resources by hiring additional care management staff, among others, and provide specific staff to train/retrain staff for programs under DSRIP projects, for example, the INTERACT program.

The Staten Island PPS plans to extensively expand upon service gaps, to meet community needs and DSRIP project requirements. For example, the PPS plans to offer wellness and health management services to lower the risk of chronic lower respiratory disease, heart disease and cancer by providing smoking cessation programs, lifestyle counseling, and cancer screenings, etc., in both primary care and mobile care settings. The PPS also plans to increase primary care capacity through expanded hours at FQHCs and in ambulatory

settings. The PPS will also leverage existing programs outside the PPS, including the Staten Island Partnership for Community Wellness' program, Tackling Youth Substance Abuse, which decrease youth alcohol and prescription drugs use.
The PPS will build upon existing care management/information technology infrastructure to promote care management capacity and enhance communication and data sharing between providers, as well as to risk stratify and identify at-risk patients.
To access and engage Staten Island's culturally and ethnically diverse population, the PPS will expand upon existing outreach programs and leverage existing relationships developed with community organizations and leaders. Additionally, the PPS plans to include a Diversity and Inclusion Committee within the PPS's overall management structure with the purpose of providing cultural competency guidance for DSRIP project implementation as well as training for providers.

Section 3.7 - Stakeholder & Community Engagement:

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

***Community 1:**
Describe, in detail, the stakeholder and community engagement process undertaken in developing the CNA (public engagement strategy/sessions, use of focus groups, social media, website, and consumer interviews).

PPS partner survey was distributed to all partners in order obtain input on the network's capabilities. Community survey was distributed to 1,000+ clients to get input on Island healthcare. The PPS asked these organizations to engage the community via survey outreach:
-Community Health Action of Staten Island (HIV Prevention, Care Coordination Services for Chronic Illness, Inmate Education and Parolee Re-entry Support, Addiction Treatment & Opioid Overdose Prevention, Food Pantry)
-Staten Island Community Friendship Clubs (Assisted Living, Senior Community)
-Staten Island Mental Health Society (BH Provider)
-Staten Island Jewish Community Center (Community Center)
-Children's Aid Society (Community-Based Organization)
-Camelot of Staten Island – Outpatient Services (Substance Abuse Provider)
-Bridge Back to Life, Staten Island (Substance Abuse Provider)
-Cerebral Palsy Association of New York State, Staten Island (Developmental Disabilities)
-Sea View Hospital Rehabilitation Center and Home (SNF)
-YMCA of Greater New York – Counseling Services - (Substance Abuse Provider)
-St. Joseph's Medical Center (BH Provider, Residential Services)
-Chait House (Health Home, BH)
-Golden Gate Rehabilitation and Health Center (SNF)
-RUMC - Outpatient Behavioral & Substance Abuse (BH Provider) and Outpatient Medical Clinics (Clinic)
-SIUH (Hospital)
-Stapleton UAME Church (Faith-Based Organization/Food Pantry)
-Jewish Community Center, Staten Island (Community-Based Organization, Community Health ED, Employment Support Services, Family Support Services)

Community survey allowed the PPS to obtain the feedback of the residents who will utilize the programs under DSRIP. 1,000 surveys were completed.

4 community focus groups (community, behavioral health, & nursing home groups), 3 PPS steering committee, and 15 PPS subcommittee meetings were held. Focus groups/committee meetings were used as forums to discuss the Island healthcare (current resources/gaps) from the prospective of the community members and partners. Partners who participated in the meetings were behavioral health, ambulatory, hospital, SNF, FQHC, home care, and physician providers.

PAC meetings were held to review community need, DSRIP project selection, workforce issues, and to solicit feedback from the PAC.

***Community 2:**
Describe the number and types of focus groups that have been conducted.

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4 1-hour focus groups were conducted to discuss healthcare from the community's perspective. Conducted at Edger Health Care and Rehabilitation Center, SIUH Community Advisory Board, Staten Island Addiction Treatment Program, and the Community Health Action of Staten Island Addiction Treatment Program. Groups ranged from 6 -33 attendees and included residents with chronic diseases, physicians & pharmacists, seniors, and wellness organizations representatives. Focus groups produced insight via the following:
-Do you feel there are services available to you to promote wellness/maintain health?
-What are the barriers that keep you from getting healthcare?
-Do you feel when you see a doctor, do you have enough time to understand the information needed to treat your or a family member's illness?
-Do you feel you, or are there people you know, who have had difficulty accessing care because of their race, gender, or religious beliefs?
-What are the top 3 things that would most improve your (or your family's) care?
-If you (your family) have been to a hospital/ER, are there any other health services that you could have used instead if they were available?

***Community 3:**

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

Community focus groups, surveys, and PPS meetings identified critical issues:
- Lack of patient education/outreach and community care are issues that need to be addressed to improve health. Residents are not aware of resources; providers can do more to engage the public. Lack of primary care providers to engage community.
- Limited practice hours/long appointment wait times pose issues for the population to receive care. There is a recognition that it is easier/quicker to access care from the ED versus private practice.
-Co-location of behavioral/medical care is needed to better serve patients. Providers consistently report the lack of appropriate ambulatory detox capacity.
-Providers recognized the need for more health coaches/care managers to progressively monitor and positively impact clients. In regard to care transitions, comprehensive care transition plans and information sharing among providers is needed to assist patients in care continuum navigation.
-Providers cited the need for better interagency/provider communication and collaboration, which can be achieved through health IT systems that provide care management, telehealth, and population-wide analytics.

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

[Richmond Univ Med Center & Staten Island Univ Hosp] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
1	Richmond University Medical Center	Co-lead applicant for Staten Island PPS. Non-profit hospital providing comprehensive inpatient and outpatient services. Mental health services, substance abuse treatment, emergency and crisis services, and evaluations. Hospital-based ambulatory care center providing patients of all ages with primary care, specialty care, and rehabilitation services. Outpatient mental health clinic provides individuals with mental illness (ages 17+) with individual and group therapy. Center provides continuing day treatment for individuals (ages 18+) who have chronic mental illness. Hospital-based program offering community support groups throughout Staten Island.	Engaging the hospitals is key to reducing inpatient admissions. The involvement of the Hospitals will support projects that involve collaborations among the Hospitals and providers within the community.
2	Staten Island University Hospital	Co-lead applicant for Staten Island PPS. Private not-for-profit, acute care hospital providing comprehensive inpatient and outpatient services. Hospital-based programs provide Staten Island residents with support group and self-help services for a wide variety of issues, illnesses, and disabilities;	Engaging the hospitals is key to reducing inpatient admissions. The involvement of the Hospitals will support projects that involve collaborations among the Hospitals and providers within the community.

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[Richmond Univ Med Center & Staten Island Univ Hosp] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		also linking individuals to a suicide help line. Health center provides adults ages 18+ with primary and specialty medical services and with WIC enrollment and services. Inpatient psychiatric services program offering patients ages 18+ in need of intensive inpatient evaluation and treatment with medication management, individual and group therapy, psychoeducation, and activity therapy. Outpatient program provides individuals 16+ with psychiatric assessment, evaluations, treatment, referrals, group therapy and pharmacology.	
3	Beacon Christian Community Health Center	Federally qualified healthcare center.	Engaging the FQHCs will present a platform to address the needs of the underserved, migrant, and homeless populations within the community. The FQHCs can assist in reducing the number of avoidable admissions by offering primary care and outpatient services.
4	Community Health Center of Richmond, Inc.	Federally qualified healthcare center.	Engaging the FQHCs will present a platform to address the needs of the underserved, migrant, and homeless populations within the community. The FQHCs can assist in reducing the number of avoidable admissions by offering primary care and outpatient services.
5	Carmel Richmond Nursing Home, Inc.	Non-profit skilled nursing facility, providing the Program of All-Inclusive Care for the Elderly (PACE) and a rehabilitation center.	With approximately 13% (60,000) of Staten Island's population being over the age of 65 (source: SI CNA), engaging the SNFs will increase their communication with acute care facilities and reduce avoidable transfers. The SNFs will be key players in Project 2bvii (Implementing INTERACT Project for SNFs) success.
6	Clove Lakes Health Care and Rehabilitation Center, Inc.	For-profit nursing home providing long-term care and rehabilitation services. Skilled nursing facility.	With approximately 13% (60,000) of Staten Island's population being over the age of 65 (source: SI CNA), engaging the SNFs will increase their communication with acute care facilities and reduce avoidable transfers. The SNFs will be key players in Project 2bvii (Implementing INTERACT Project for SNFs) success.
7	New Vanderbilt Rehabilitation & Care Center	For-profit nursing home offering long- and short-term rehabilitation, sub-acute rehab, a 40-bed ventilator and pulmonary care unit, and hospice care. Skilled nursing facility.	With approximately 13% (60,000) of Staten Island's population being over the age of 65 (source: SI CNA), engaging the SNFs will increase their communication with acute care facilities and reduce avoidable transfers. The SNFs will be key players in Project 2bvii (Implementing INTERACT Project for SNFs) success.

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[Richmond Univ Med Center & Staten Island Univ Hosp] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
8	Richmond Center for Rehabilitation and Residential Healthcare	Non-profit nursing home with long-term ventilator unit, HIV/AIDS unit, behavioral health unit, and short-term rehabilitation center. Skilled nursing facility.	With approximately 13% (60,000) of Staten Island's population being over the age of 65 (source: SI CNA), engaging the SNFs will increase their communication with acute care facilities and reduce avoidable transfers. The SNFs will be key players in Project 2bvii (Implementing INTERACT Project for SNFs) success.
9	Staten Island Care Center	For-profit nursing home offering long- and short-term rehabilitation, Alzheimer's and dementia care, respite care, and end-of-life care. Skilled nursing facility.	With approximately 13% (60,000) of Staten Island's population being over the age of 65 (source: SI CNA), engaging the SNFs will increase their communication with acute care facilities and reduce avoidable transfers. The SNFs will be key players in Project 2bvii (Implementing INTERACT Project for SNFs) success.
10	Eger Health and Rehabilitation Center	Non-profit geriatric care center including nursing home providing long-term care and respite care, Eger Harbor House assisted living facility, short-term rehabilitation center, hospice services. Skilled nursing facility.	With approximately 13% (60,000) of Staten Island's population being over the age of 65 (source: SI CNA), engaging the SNFs will increase their communication with acute care facilities and reduce avoidable transfers. The SNFs will be key players in Project 2bvii (Implementing INTERACT Project for SNFs) success.
11	Silver Lake Specialized Care Center	For-profit skilled nursing facility offering long- and short-term rehabilitative care, stroke rehabilitation, sub-acute care, pain management, a hospice program, long-term care ventilator and pulmonary sub-acute units, respite care, and Alzheimer' care.	With approximately 13% (60,000) of Staten Island's population being over the age of 65 (source: SI CNA), engaging the SNFs will increase their communication with acute care facilities and reduce avoidable transfers. The SNFs will be key players in Project 2bvii (Implementing INTERACT Project for SNFs) success.
12	Golden Gate Rehabilitation and Health Care Center	For-profit nursing home offering long- and short-term rehabilitation, sub-acute care, IV therapy, wound and tracheostomy care, respiratory therapy, pain management, bariatric wellness program, complex medical and post-surgical care, and prostheses. Skilled nursing facility.	With approximately 13% (60,000) of Staten Island's population being over the age of 65 (source: SI CNA), engaging the SNFs will increase their communication with acute care facilities and reduce avoidable transfers. The SNFs will be key players in Project 2bvii (Implementing INTERACT Project for SNFs) success.
13	Verrazano Nursing Home, Inc.	For-profit nursing home offering long- and short-term rehabilitation, skilled nursing, tracheostomy and wound care, pastoral and hospice care, sub-acute care, IV therapy, pain management, respite care, and Alzheimer's and dementia care.	With approximately 13% (60,000) of Staten Island's population being over the age of 65 (source: SI CNA), engaging the SNFs will increase their communication with acute care facilities and reduce avoidable transfers. The SNFs will be key

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[Richmond Univ Med Center & Staten Island Univ Hosp] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			players in Project 2bvii (Implementing INTERACT Project for SNFs) success.
14	Seaview Hospital Rehabilation Center and Home	Public nursing home, adult day health care center, and rehabilitation center; with specialty unit for patients with traumatic brain injuries requiring extended care. Skilled nursing facility.	With approximately 13% (60,000) of Staten Island's population being over the age of 65 (source: SI CNA), engaging the SNFs will increase their communication with acute care facilities and reduce avoidable transfers. The SNFs will be key players in Project 2bvii (Implementing INTERACT Project for SNFs) success.
15	Coordinated Behavioral Care (CBC)	A multi-provider health home focused on individuals with a behavioral health condition.	Engaging the health home will be key in supporting the goals of Project 2aiii (Health Home At Risk). CBC is the only health home on Staten Island and operates through multiple organizations within the borough. The CBC infrastructure and care management model will be leveraged to serve additional at-risk patients, linking them to primary care physicians (PCP), hospitals, behavioral health and substance abuse providers, among others. The CBC model will also enable the PPS to identify at-risk patients and engage them.
16	South Beach Psychiatric Center	Public mental health provider of inpatient services, and well as outpatient assessment and treatment for adults, children and adolescents, including pharmacotherapy, individual and group therapy, rehabilitation, medication management, intensive case management, employment and self-help services, co-occurring substance abuse addictions.	Behavioral health (BH) and substance abuse (SA) accounted for approximately 30% of Medicaid enrollee readmissions to RUMC and SIUH (SI PPS CNA). Engaging South Beach Psychiatric Center will enable the PPS to target readmissions for BH and SA chronic diseases in outpatient and inpatient settings.
17	Staten Island Mental Health Society	Mental health provider of inpatient services, and well as outpatient assessment and treatment for adults, children and adolescents, including therapy and medication management.	Behavioral health (BH) and substance abuse (SA) accounted for approximately 30% of Medicaid enrollee readmissions to RUMC and SIUH (SI PPS CNA). Engaging Staten Island Mental Health Society will enable the PPS to target readmissions for BH and SA chronic diseases in outpatient and inpatient settings.
18	St. Joseph's Medical Center	Mental health provider of inpatient services, and well as outpatient assessment and treatment for adults, children and adolescents, including therapy and medication management. OASAS (Article 32) Provider.	Behavioral health (BH) and substance abuse (SA) accounted for approximately 30% of Medicaid enrollee readmissions to RUMC and SIUH (SI PPS CNA). Engaging St. Joseph's Medical Center will enable the PPS to target readmissions for BH and SA chronic diseases in outpatient and inpatient settings.

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[Richmond Univ Med Center & Staten Island Univ Hosp] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
19	Community Health Action of Staten Island	Provides: HIV prevention, care coordination services for chronic illness, education for inmates and re-entry support for parolees, addiction treatment and opioid overdose prevention, food pantry) services. OASAS (Article 32) Provider.	The CBC infrastructure and care management model will be leveraged to serve additional at-risk patients, linking them to primary care physicians (PCP), hospitals, behavioral health and substance abuse providers, among others. The CBC model will also enable the PPS to identify at-risk patients and engage them.
20	Staten Island Community Friendship Clubs	Non-profit assisted living senior center providing seniors ages 60+ with activities, meals, and transportation to and from the center.	Engaging the senior citizen centers will aide in the reduction of readmissions of the aging population.
21	Children's Aid Society	Non-profit multi-service center providing children and families in Staten Island with educational and recreational programs. Community-based organization.	Develops the foundation for healthy choices in the youth that can potentially help lower avoidable hospital use once they become adults.
22	Camelot of Staten Island, Inc.	Non-profit outpatient substance abuse program offering adolescents and adults individual, group, and family counseling/therapy and vocational and educational support; also offers free support groups for individuals in the community whose family or friends of individuals dealing with substance abuse. Day program provides teens (ages 14-19) with substance abuse treatment and GED completion/high school reentry services; program includes individual and group counseling, workshops, vocational training, and job placement assistance. A 9- to 12-month residential substance abuse program offering adolescent males (ages 18-25) individual, group, and family counseling/therapy; education; and vocational training. OASAS (Article 32) Provider.	Engaging Camelot of Staten Island, Inc. will enable the PPS to target readmissions for BH and SA chronic diseases primarily in outpatient and select inpatient settings.
23	Bridge back to life, Staten Island	For-profit outpatient mental health and substance abuse treatment center offering adolescents and adults psychiatric evaluation and treatment, counseling and psychotherapy, DUI/DWI support, education, crisis intervention, and referral services.	Engaging Bridge Back to Life will enable the PPS to target readmissions for BH and SA chronic diseases in outpatient settings.
24	Samaritan Village (CBC)	OASAS (Article 32) Provider.	The CBC infrastructure and care management model will be leveraged to serve additional at-risk patients, linking them to primary care physicians (PCP), hospitals, behavioral health and substance abuse providers, among others. The CBC model will also enable the PPS to identify at-risk patients and engage them.
25	Silver Lake Support Services, Inc.	Medically supervised chemical dependency treatment center providing adults (18+) who suffer from alcohol and drug abuse with outpatient treatment, a Mentally Ill Chemically Addicted (MICA) outpatient program, support groups, and case management. OASAS (Article 32) Provider.	Engaging Silver Lake Support Services will enable the PPS to target readmissions for BH and SA chronic diseases in outpatient settings.
26	Cerebral Palsy of NYS	Non-profit day rehabilitation program offering adults (18+) with developmental disabilities individualized services, such as nursing care, physical and	Engaging the disabled population to make health care more accessible and aid in the potential reduction of

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[Richmond Univ Med Center & Staten Island Univ Hosp] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		occupational therapy, daily living assistance, and community integration programs. Diagnostic and Treatment Center.	avoidable hospitalizations.
27	HeartShare Wellness (CPA)	A community-based health care center that provides high quality, patient-friendly health care services to children and adults with intellectual and developmental disabilities who live in New York City and surrounding communities. Diagnostic and Treatment Center.	Engaging the population living with intellectual and developmental disabilities to make health care more accessible and aid in the potential reduction of avoidable hospitalizations.
28	YMCA of Greater NY- Counseling Service Branch	Non-profit, multilingual information resource and referral center providing immigrant families with instructional, vocational, recreational, family support, and social services, including English as a Second Language, cultural orientation, and citizenship.	The YMCA will engage low-utilizers and educate them on available health care resources.
29	Chait House	Not-for-profit transitional housing residence providing adults with mental illness with 24-hour supervision and therapeutic programs. Health home and behavioral health provider.	Engaging Chait House will enable the PPS to target readmissions for BH and SA chronic diseases in outpatient settings.
30	Stapleton UAME Church	Faith-based organization and food pantry services.	Stapleton UAME Church will allow the PPS to engage low-utilizers and educate them on available health care resources.
31	Jewish Community Center of Staten Island	Non-profit center providing Staten Island community members with programs in fitness, sports, education, and Jewish culture, as well as a number of community service programs for children, adults, and seniors in need. Community-based organization, community health education, employment services, and family support services.	Jewish Community Center of Staten Island will allow the PPS to engage low-utilizers and educate them on available health care resources.
32	SIUH Community Advisory Board	Works to improve the quality of life for Staten Island residents.	SIUH Community Advisory Board will allow the PPS to engage the population and educate them on available health care resources.
33	Catholic Managed Long Term Care (ArchCare Senior Life)	Managed Care Organization.	Engaging the MCOs will enable the PPS to improve the quality of care received by Medicaid enrollees while identifying at-risk members of the population.
34	Healthfirst PHSP, Inc.	Among the top 5 managed care organizations for Staten Island Medicaid enrollee equivalents.	Engaging the MCOs will enable the PPS to improve the quality of care received by Medicaid enrollees while identifying at-risk members of the population.
35	HealthPlus Amerigroup	The largest managed care organization for Staten Island Medicaid enrollee equivalents.	Engaging the MCOs will enable the PPS to improve the quality of care received by Medicaid enrollees while identifying at-risk members of the population.
36	OHEL Children's Home and Family Services (CBC)	Behavioral Housing Support.	The CBC infrastructure and care management model will be leveraged to serve additional at-risk patients, linking them to primary care physicians (PCP), hospitals, behavioral health and substance abuse providers, among others. The CBC model will also enable the PPS to identify at-risk patients and engage

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#	Organization	Brief Description	Rationale
			them.
37	Calvary Home Care	Certified Home Health Agency.	Avoiding unnecessary Hospital utilization by offering healthcare accessibility for patients. In collaboration with other PPS providers, will support Project 2biv (Care Transitions to Reduce 30-Day Readmission).
38	Empire State Home Care Services	Certified Home Health Agency.	Avoiding unnecessary Hospital utilization by offering healthcare accessibility for patients. In collaboration with other PPS providers, will support Project 2biv (Care Transitions to Reduce 30-Day Readmission).
39	North Shore Home Care (NSLIJ Health System)	Certified Home Health Agency.	Avoiding unnecessary Hospital utilization by offering healthcare accessibility for patients. In collaboration with other PPS providers, will support Project 2biv (Care Transitions to Reduce 30-Day Readmission).
40	Region Care Nursing Agency (NSLIJ)	Certified Home Health Agency.	Avoiding unnecessary Hospital utilization by offering healthcare accessibility for patients. In collaboration with other PPS providers, will support Project 2biv (Care Transitions to Reduce 30-Day Readmission).
41	Visiting Nurse Association Health Care Services, Inc. d/b/a VNA of Staten Island	Non-profit home care provider offering individuals and families home-based maternal child care, long-term care, AIDS care, wound care, and Early Intervention for children. Certified Home Health Agency.	Avoiding unnecessary Hospital utilization by offering healthcare accessibility for patients. In collaboration with other PPS providers, will support Project 2biv (Care Transitions to Reduce 30-Day Readmission).
42	Visiting Nurse Service of New York Home Care	Certified Home Health Agency.	Avoiding unnecessary Hospital utilization by offering healthcare accessibility for patients. In collaboration with other PPS providers, will support Project 2biv (Care Transitions to Reduce 30-Day Readmission).
43	Person Centered Care Services	Not for Profit Social Services organization. Providing people with developmental disabilities the ability to identify their dreams and find ways to develop their skills and goals to makre their dreams a reality. Behavioral Health-Client Support.	Engaging the population living with developmental disabilities to make health care more accessible and aid in the potential reduction of avoidable hospitalizations.
44	South Beach Addiction Treatment Center	Public short-term inpatient addiction treatment center offering chemically addicted adults (ages 18+) individual, group and family counseling; special issue groups (relapse, HIV, etc.); experiential groups; educational lectures; self-help meetings.	Behavioral health (BH) and substance abuse (SA) accounted for approximately 30% of Medicaid enrollee readmissions to RUMC and SIUH (SI PPS CNA). Engaging South Beach Addiction Treatment Center will enable the PPS to target readmissions for BH and SA chronic

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#	Organization	Brief Description	Rationale
			diseases in inpatient settings.
45	Staten Island Behavioral Network, Inc. (CBC)	Behavioral Health-Client Support.	The CBC infrastructure and care management model will be leveraged to serve additional at-risk patients, linking them to primary care physicians (PCP), hospitals, behavioral health and substance abuse providers, among others. The CBC model will also enable the PPS to identify at-risk patients and engage them.
46	Sky Light Center (CBC)	Non-profit clubhouse providing individuals (ages 18+) with severe and persistent mental illness with support and rehabilitation services, such as job placement, vocational training, daily meals, food pantry, social and recreational activities, affordable housing support. Behavioral Health-Client Support.	The CBC infrastructure and care management model will be leveraged to serve additional at-risk patients, linking them to primary care physicians (PCP), hospitals, behavioral health and substance abuse providers, among others. The CBC model will also enable the PPS to identify at-risk patients and engage them.
47	Catholic Charities Community Services	Provides a comprehensive range of professional human services. The major service areas are: case management, information and referral, emergency food services, employment training and placement, homelessness prevention, immigration and refugee services, parish support, thrift store, blind services, deaf apostolate, residential services for the mentally challenged, youth recreational and spiritual services. Community benefit organization.	Catholic Charities Community Services will allow the PPS to engage low-utilizers and educate them on available health care resources.
48	Mission of the Immaculate Virgin (CPA)	Provides residential care for developmentally disabled children and young adults. MIV also operates a community day care center. MIV is the host for two public schools; a socialization program for recovering alcoholics called Traditions House; a senior citizens nutrition program called the Friendship Club; a counseling service for women with unplanned pregnancies called Cross-Road Foundation; MIV has cooperative agreements with each of these groups including, but not limited to, leases on buildings. Community benefit organization.	Mission of the Immaculate Virgin will allow the PPS to engage low-utilizers and educate them on available health care resources.
49	Jewish Board of Family and Children's Services (CBC)	Non-profit program offering supportive services for at-risk families, including those at risk of abuse or neglect, those with emotionally troubled teenagers, those with mental health and/or substance abuse disorders, and those involved in the criminal justice system. Provides Staten Island children and adolescents (5-18 years) with home-based short-term crisis intervention, assistance with substance abuse, 24-hour respite care for up to 3 weeks, and connections/referrals to other community and social service resources. Family support program offers parents of seriously emotionally disturbed or physically disabled children and adolescents (up to age 21) education and information, workshops, advocacy, support groups, respite care, family recreation events, an OMH support. (Article 31)	The CBC infrastructure and care management model will be leveraged to serve additional at-risk patients, linking them to primary care physicians (PCP), hospitals, behavioral health and substance abuse providers, among others. The CBC model will also enable the PPS to identify at-risk patients and engage them.

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[Richmond Univ Med Center & Staten Island Univ Hosp] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		Provider.	
50	Project Hospitality (CBC)	Non-profit center providing individuals who are homeless or living with multiple diagnoses with services including, mental health and chemical dependency; case management; legal advocacy; housing; medical care including HIV testing; and harm reduction. Social services center offers adults ages 18+ who are HIV+ with primary care services, housing assistance, mental health services, case management, harm reduction services and treatment adherence. Drop-in center provides homeless individuals (ages 21+) with food; showers; clothing; psychiatric care; primary health care; and referrals to detox, rehab, and housing. (Article 31) Provider.	The CBC infrastructure and care management model will be leveraged to serve additional at-risk patients, linking them to primary care physicians (PCP), hospitals, behavioral health and substance abuse providers, among others. The CBC model will also enable the PPS to identify at-risk patients and engage them.
51	The Staten Island Mental Health Society (CBC)	SIMHS providing outpatient therapy for children (up to age 21) who are emotionally or behaviorally disturbed, developmentally or learning disabled, neurologically impaired, dependent on alcohol or drugs, and/or economically disadvantaged. OMH (Article 31) Provider.	The CBC infrastructure and care management model will be leveraged to serve additional at-risk patients, linking them to primary care physicians (PCP), hospitals, behavioral health and substance abuse providers, among others. The CBC model will also enable the PPS to identify at-risk patients and engage them.
52	University Physicians Group	University Physicians Group is a multi-specialty medical group of healthcare professionals committed to providing high quality, accessible healthcare to both Staten Island and southern Brooklyn.	Physician groups will enable the PPS to engage patients not currently utilizing the healthcare system (or primarily seeking care in the emergency department (ED) by connecting them to primary and preventive services and financially accessible healthcare resources.
53	Victory Internal Medicine, P.C.	Medical group practice.	Physician groups will enable the PPS to engage patients not currently utilizing the healthcare system (or primarily seeking care in the emergency department (ED) by connecting them to primary and preventive services and financially accessible healthcare resources.

Section 3.8 - Summary of CNA Findings:

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

***Community Needs:**
Needs below should be ordered by priority, and should reflect the needs that the PPS is intending to address through the DSRIP program and projects. Each of the needs outlined below should be appropriately referenced in the DSRIP project section of the application to reinforce the rationale for project selection.

You will use this table to complete the Projects section of the application. You may not complete the Projects Section (Section 4) until

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

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this table is completed, and any changes to this table will require updates to the Projects Section.

[Richmond Univ Med Center & Staten Island Univ Hosp] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
1	Need for quality improvement program focusing on management of acute condition to avoid transfer	Need for a quality improvement program that focuses on the management of acute changes in a patient's condition to avoid transfer to an acute care facility (Project 2.b.vii INTERACT). Staten Island's Medicaid patients make up an estimated 1,500 transfers from skilled nursing facilities to acute care facilities annually. Respiratory distress/shortness of breath, altered mental status, abnormality of gait, gastro-intestinal, cardiac, sepsis, abnormal lab tests/vitals, pneumonia, renal failure and cerebrovascular complications are reported as top reasons for transfers from SNF to acute care facilities. Additionally, Staten Island has approximately 1,639 Medicaid PQI admissions annually and 1,171 Potentially Avoidable Readmissions. The Staten Island PPS could benefit from a comprehensive program that aims to reduce the transfers from skilled nursing facilty to acute (the subset of the 1500 annual transfers) that could have been avoided.	• Staten Island PPS Provider Data, Work Groups • Potentially Avoidable Readmissions– 3M • PQI Suite – Composite of all measures – AHRQ
2	Need for implementation of INTERACT-like program in the home care setting for high risk patients	Need for implementation of INTERACT-like program in the home care setting to reduce risk of re-hospitalizations for high risk patients (Project 2.b.viii Home Care). Staten Island's Medicaid enrollee population had 3,915 30-day readmissions which account for approximately 18% of total admissions. Approximately 28% of readmissions are attributed to the dual eligible population. Staten Island PPS home care providers estimate that approximately 600 30-day readmissions are related to patients who were discharged to home care facilities. Providers reported that the top reasons for readmission among home care patients include respiratory conditions (pneumonia or bronchitis), wound infection, deterioration, uncontrolled pain, and dehydration or malnutrition. Providers also cite that readmission might have been better controlled with in-home medical care management, home care services or proper	• Staten Island PPS Provider Data • New York State SPARCS database

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[Richmond Univ Med Center & Staten Island Univ Hosp] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		connection to outpatient services.	
3	Need for increase in access to palliative care programs	Need for increase in access to palliative care programs (Project 3.g.ii Palliative Care). Staten Island has the highest overall mortality rates of New York City's five boroughs, with 679.8 deaths per thousand residents compared to 622.7 deaths per thousand residents for the NYC average. In addition to high mortality rates, Staten Island's Medicaid Per-Member-Per-Month (PMPM) costs are the highest for Staten Island's population above the age of 80. 2 83 Staten Island Medicaid recipients received nursing home care for palliative-related diagnoses (e.g. cancer, liver disease, dementia, congestive heart failure, etc.) during the 2010-2012, only approximately 90 patients on Staten Island are currently receiving palliative care.	• NYS NYSDOH Vital Statistics • Salient New York State Medicaid Claims Database
4	Need for integration of behavioral health and substance abuse with primary care services	Need for integration of behavioral health and substance abuse with primary care services (Project 3.a.i Behavioral Health Integration). Of Staten Island's Medicaid population, 28,868 Medicaid recipients had a behavioral health diagnosis. This population was also attributed to 10,640 Medicaid mental health (MH) hospital admissions and 14,108 Medicaid mental health ED visits in 2012 as well as 6,826 substance abuse admissions and 6,172 substance abuse-related ED visits. Of SI's 30-day readmissions in 2013, approximately 30% were attributed to behavioral health and substance abuse with related medical readmissions due to chronic conditions including circulatory and respiratory disorders, diabetes, acute kidney failure, cardiac disease, infections, and cancer. Of the Medicaid/dual eligible hospitalizations during 2013, Staten Island had a total of 2,080 admissions where the patient had both a behavioral health and chronic condition diagnosis. Further supporting this data, the Staten Island PPS BH & SA providers indicate that all or a large percentage of their current patients would benefit from access to primary care/medical services.	• Provider Survey, Provider Workgroups • PPV (for persons with BH diagnosis) - NCQA • New York State SPARCS database
5	Need to develop withdrawal management services for substance use disorders (ambulatory detox)	Need to develop withdrawal management services for substance use disorders (ambulatory detox) (Project 3.a.iv Withdrawal Management).	• Provider Workgroups, Community Survey, Provider Data • PPV (for persons with

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[Richmond Univ Med Center & Staten Island Univ Hosp] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		According to survey results, 20% of Staten Island's community members identified substance abuse/alcohol addiction as a primary health condition for which they seek care. Supporting this finding, In 2012, Staten Island's Medicaid population had 6,826 Substance abuse admissions & 6,172 Substance abuse-related ED visits. Of Staten Island's 3,915 30-day readmissions approximately 1,133 admissions (30%) were attributed to substance abuse or psychiatric disorders. 2012, the Staten Island rate of deaths per 100,000 from drug overdoses was 20.1, far exceeding the Bronx at 16.5 & all of the five boroughs. Further, Staten Island's overdose mortality rate has increased by 8 percentage points from 12.0 per 100,000 in 2010 to 20.1 per 100,000 in 2012. Staten Island had 653 Medicaid recipients with an inpatient discharge & a substance abuse diagnosis in 2013-2014. Participating PPS providers consistently reported a lack of appropriate ambulatory detox capacity on Staten Island as a significant gap in the current delivery system.	BH diagnosis) – NCQA • New York State SPARCS database • New York City Department of Health and Mental Hygiene Epiquery Statistics • Salient New York State Medicaid Claims Database
6	Need for strengthened mental health and substance abuse infrastructure across systems	Need for strengthened mental health and substance abuse infrastructure across systems including prevention partnerships and cultural and linguistic training on MEB health promotion, prevention and treatment (Project 4.a.iii Mental Health & Substance Abuse Infrastructure). In the past year, approximately 21% (28,868) of Staten Island's Medicaid population had a mental health or substance abuse diagnosis. This population also had 10,640 Medicaid mental health hospital admissions and 14,108 Medicaid mental health ED visits in 2012, as well as 6,826 substance substance abuse admissions and 6,172 substance abuse-related ED visits. According to survey results, 20% of Staten Island's community members identified substance abuse/alcohol addiction as a primary health condition for which they seek care. Of the 3,915 30-day readmissions for the Medicaid population 30% were attributed to behavioral health or substance abuse issues. In 2012, the Staten Island rate of deaths per	• Provider Workgroups, Community Survey • PPV (for persons with BH diagnosis) – NCQA • New York State SPARCS database • New York City Department of Health and Mental Hygiene Epiquery Statistics • Salient New York State Medicaid Claims Database

Richmond Univ Med Center & Staten Island Univ Hosp (PPS ID:43)

[Richmond Univ Med Center & Staten Island Univ Hosp] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		100,000 from drug overdoses was 20.1, far exceeding the Bronx at 16.5 and all of the five boroughs. Further, Staten Island's overdose mortality rate has increased by 8 percentage points from 12.0 per 100,000 in 2010 to 20.1 per 100,000 in 2012.	
7	Need to expand access to primary care services and develop integrated care teams	Need to expand access to primary care services and develop integrated care teams to meet the needs of high risk patients (Project 2.a.iii Health Home). Staten Island has the highest rate of mortality in NYC (679.8 per 100,000 compared to a citywide aggregate of 622.7 per 100,000). Staten Island also has approximately 1,600 PQI admissions annually, which is also higher than the New York City and New York State average admission rates. Among Staten Island's top causes of PQI admissions are chronic diseases including COPD, diabetes, heart failure, and hypertension, among others. Patients are identified with a primary diagnosis of the following chronic conditions: asthma (6,962), diabetes (9,566), hypertension (12,939), congestive heart failure (1,693), and chronic obstructive pulmonary disease and bronchiectasis (4,118) (these patients may be duplicates). Staten Island community members and providers report difficulty accessing primary care services including transportation barriers, and lack of extending office hours and long waiting times. High patients, included those listed above could benefit from comprehensive care management services but do not qualify under the current NYS standards as well as expanded access to primary care services.	• Provider Survey, Community Survey • New York State Department of Health Vital Statistics • PQI Suite – Composite of all measures – AHRQ • Medicaid Salient data • Provider Work groups
8	Need for greater care transition support to prevent 30-day readmissions for at-risk populations	Need for greater care transition support to prevent 30-day readmissions for at-risk populations (Project 2.b.iv Care Transitions). Staten Island's Medicaid enrollee population had 3,915 30-day readmissions which account for approximately 18% of total admissions. Of these readmissions, approximately 30% were attributed to behavioral health, substance abuse, and chronic conditions including circulatory and respiratory disorders, diabetes, acute kidney failure, cardiac disease, infections, and cancer. Approximately 28% of readmissions are attributed to the dual eligible population.	• New York State SPARCS database • Potentially Avoidable Readmissions– 3M • PQI Suite – Composite of all measures – AHRQ

Richmond Univ Med Center & Staten Island Univ Hosp (PPS ID:43)

[Richmond Univ Med Center & Staten Island Univ Hosp] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		1,171 readmissions were identified as potentially preventable readmissions (PPR). Annually, Staten Island has approximately 1,600 PQI admissions of which the numbers of types of PQI admissions are higher than the NYC and New York State averages. These numbers indicate that Staten Island's Medicaid population would benefit from 30-day readmission care support to support high risk patients at risk for readmission.	
9	Need for evidence-based strategies for diabetes in at-risk populations	Need for evidence-based strategies for diabetes in at-risk populations (Project 3.c.i Diabetes Management). Staten Island has approximately 14,025 Medicaid recipients with a diabetes diagnosis. 20% of the 1,639 Staten Island Medicaid PQI hospitalizations were due to Type II Diabetes related complications. Staten Island's death rate related to heart disease death is higher than NYC's average rate. This finding is significant as heart disease is commonly linked to diabetes. This high rate can in part be explained by Staten Island's overweight and obese population and high smoking rates (highest rate of the five boroughs) which either have diabetes or are at-risk for developing diabetes. To address these findings, diabetes self-management training, can create significant opportunities to improve health status and longevity on Staten Island.	• PQI # 1 (DM Short term complications) - AHRQ • PQI Suite – Composite of all measures – AHRQ • Salient New York State Medicaid Claims Database • New York State Department of Health Vital Statistics • New York City 2012 Epiquery statistic
10	Need for increased access to high quality preventative care and management of chronic conditions	Need for increased access to high quality preventative care and management of chronic conditions (Project 4.b.ii Chronic Conditions Management). Among Staten Island's leading causes of PQI hospitalizations are admissions related to COPD or asthma (453 or 28% of the population) and hypertension (128 or 8% of the population). In certain hot spots, including Mariners Harbor for lung and prostate cancer, present rates are15.0% - 49.9% greater than expected. Staten Island has high household income yet continues to be the borough with the highest mortality rate (679.8 compared to a citywide aggregate of 622.7 per 100,000). Leading causes of death, over NYC rates, relate to cardiac, cancer, and respiratory diseases.	• PQI Suite – Composite of all measures – AHRQ • Salient New York State Medicaid Claims Database • New York State Department of Health Vital Statistics • New York City 2012 Epiquery statistic

Richmond Univ Med Center & Staten Island Univ Hosp (PPS ID:43)

[Richmond Univ Med Center & Staten Island Univ Hosp] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		36.2% of Staten Island residents between the ages of 45 and 64 years are considered obese as well as 34.8% of residents between the ages of 25 and 44. Additionally, Staten Island is identified as the borough with the highest percentage of current smokers, 16.5%	
11	Need to engage uninsured & non/low utilizing Medicaid population to reduce inappropriate utilization	Need to engage the uninsured and non/low utilizing Medicaid population in Patient Activation measures to reduce inappropriate utilization of hospitals and emergency departments and connect patients to prevention and management. (Project 2.d.i). Staten Island's uninsured and low/non-utilizing Medicaid populations make up approximately 15% of the total population. There are 53,428 uninsured patients on Staten Island (11% of the population), 8,240 non-utilizing Medicaid enrollees, and approximately 11,000 low-utilizer Medicaid enrollees. These populations are identified as being ethnically diverse which present linguistic and cultural barriers for Medicaid enrollees and the uninsured attempting to self-manage care and access/navigate Staten Island's healthcare system.	• Staten Island PPS Provider Survey, Provider data, Provider Workgroups • New York City Department of Health and Mental Hygiene Epiquery Statistics • Salient New York State Medicaid Claims Database

File Upload: (PDF or Microsoft Office only)
Please attach the CNA report completed by the PPS during the DSRIP design grant phase of the project.

File Name	Upload Date	Description
43_SEC038_Staten Island PPS CNA Report_Section E_Dec 2014.pdf	12/22/2014 02:18:09 PM	Staten Island PPS CNA Report and Summary of Findings
43_SEC038_Staten Island PPS CNA Databook_Provider Surveys_Community Surveys_Dec 2014.pdf	12/22/2014 02:12:52 PM	Staten Island PPS CNA Databook and Survey summary

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

DSRIP PPS Organizational Application

Richmond Univ Med Center & Staten Island Univ Hosp (PPS ID:43)

SECTION 4 – PPS DSRIP PROJECTS:

Section 4.0 – Projects:

Description:
In this section, the PPS must designate the projects to be completed from the available menu of DSRIP projects.

Scoring Process:
The scoring of this section is independent from the scoring of the Structural Application Sections. This section is worth 70% of the overall Application Score, with all remaining Sections making up a total of 30%.

Please upload the Files for the selected projects.

***DSRIP Project Plan Application_Section 4.Part I (Text):** (Microsoft Word only)

Currently Uploaded File: **Richmond_Section4_Text_DSRIP Project Plan Application _ Section 4 Final.docx**

Description of File

Section 4 DSRIP Project Plan Sections for Staten Island PPS

File Uploaded By: rb426896

File Uploaded On: 12/21/2014 07:45 PM

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

Currently Uploaded File: **Richmond_Section4_ScopeAndScale_Section 4 SI PPS Project App _ Scale Speed only _ for submission.xlsx**

Description of File

Preliminary Scale and Speed

File Uploaded By: rb426896

File Uploaded On: 12/22/2014 03:06 PM

Richmond Univ Med Center & Staten Island Univ Hosp (PPS ID:43)

SECTION 5 – PPS WORKFORCE STRATEGY:

Section 5.0 – PPS Workforce Strategy:

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

The following subsections are included in this section:

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

Scoring Process:

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

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

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

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

***Strategy 1:**
In the response, please include

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

Staten Island (SI) PPS developed a workforce strategy, together with the Steering Committing, Project Advisory Committee (PAC), Co-Leadership, and PPS provider representatives. SI PPS identified the following drivers of change: 1) potential reduction in staffing needs in inpatient settings at Staten Island University Hospital (SIUH) and Richmond University Medical Center (RUMC) leading to required redeployment 2) the need for new positions in outpatient settings including at RUMC and SIUH for the implementation of the 11 DSRIP projects 3)ability to redeploy/retrain staff currently working in inpatient settings to outpatient hospital settings 4) expected normal attrition.

SI PPS completed a high level assessment of its current workforce, including identifying existing staff across the PPS partners (hospitals,

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Skilled Nursing facilities, home care agencies, behavioral health and substance abuse providers, Federally Qualified Health Centers, among others). SI PPS believes potential reductions in PQI/PDI admissions, readmissions, and Emergency Department (ED) visits at the two SI hospitals will impact workers currently employed in inpatient settings in these organizations. This impact is estimated to be seen over time, with no impact expected in Demonstration Year 1 (DY1). The impact will likely be seen by DY3; however staff redeployment may be required over the course of the 5 years at RUMC and SIUH. The total employee population of the PPS is approximately 13,000, with an estimated 8,200 hospital staff. Of the 8,200 hospital staff, the SI PPS estimates 5% of hospital staff (3% of SI PPS staff) or 410 staff may be redeployed by DY 5.
SI PPS envisions that as more care is delivered in the community and in outpatient settings, and less in inpatient settings, the DSRIP program will create the need for a "new" workforce to expand services in ambulatory provider settings and community based organizations. SI PPS performed a high level assessment to gage possible new positions and estimated 400 new positions may be required to implement the DSRIP projects. New positions include additional primary care physicians to expand services to the uninsured and non/underutilizing, and extend hours and expand preventive and management services for patients with chronic diseases. New positions will also include psychiatrists and social workers to expand ambulatory detox, and to integrate behavioral health and primary care services, among others.

A subset of the workforce identified will require some level of retraining. SI PPS expects approximately 43% of the PPS workforce will require retraining under the DSRIP program.
As an immediate need, the workforce strategy will include the recruitment of new professionals required to begin implementation of the 11 DSRIP projects, as well as the development of training programs that will need to quickly ramp up to meet DSRIP milestones. As the DSRIP projects ramp up and additional new positions need to be filled, the PPS will also see reductions in hospitalizations and ER visits leading to replyment (likely in DY3). The PPS will work to redeploy staff first to the outpatient settings at SIUH and RUMC, and to other PPS providers as required.

SI PPS anticipates that the following positions will be impacted (RT = retrain, RD = redeploy):
Administrative/Clerks/Registrars – RT, RD; Behavioral Health/Substance Abuse Counselors – RT, RD; Case Managers - RT, RD; Clinical Nursing Assistants – RT, RD; Educators – RT, RD; Lab Technicians – RT, RD; Licensed Practical Nurses – RT, RD; Medical Assistants – RT, RD; Nurse Practitioners – RT; Physician Assistants – RT; Physicians – RT; Psychiatrists – RT; Registered Nurses – RT, RD.

It is anticipated that the PAC, together with the Workforce Committee, and the Steering Committee will address the ongoing needs of the workforce over time.

***Strategy 2:**

In the response, please include

- Please describe the PPS' approach and plan to minimize the workforce impact, including identifying training, re-deployment, recruiting plans and strategies.
- Describe any workforce shortages that exist and the impact of these shortages on the PPS' ability to achieve the goals of DSRIP and the selected DSRIP projects.

The SI PPS lead entities, RUMC and SIUH, have recent experience with staff redeployment due to reduction in services at each of their facilities. The SI PPS will leverage this experience in working with key stakeholders and union representatives to mitigate negative impacts on current staff. The SI PPS will also leverage the support of the 1199SEIU Training and Employment Fund (TEF). As previously stated, although reduction in inpatient admissions at SIUH and RUMC may require redeployment and retraining of staff, the planned expansion of outpatient programs at SIUH and RUMC through the implementation of the DSRIP projects will create new opportunities for redeployment and retraining. When redeployment/retraining is not possible, the PPS is confident that through normal staff attrition, and working with its workforce partners, including union representatives through the process that already exists, the PPS will be able to mitigate any negative impact on the workforce. As stated, the PPS believes the number of staff that will not be able to be redeployed will be minimal.

The PPS identified the ability to hire certain staff as a challenge to project implementation and the ability of the PPS to meet project goals. Many of the projects that the PPS will implement require specialized staff that have been difficult to recruit in the past and will likely continue to be a challenge going forward. Further, SI is geographically isolated with a high cost to commute which creates an even greater barrier to recruiting needed staff. The SI PPS will consider appropriate incentive payments to partially cover the high costs to commute.

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The SI PPS is implementing multiple projects that require additional psychiatrists that are difficult to recruit. Specialized Nurse Practitioners for the expansion of palliative care in nursing homes may also be difficult to recruit. PPS providers report this will impact project implementation timelines. The PPS has identified a shortage of home health aides on Staten Island as a current challenge that will continue to be a challenge. This shortage exists because of the high cost to commute to SI, as well as the low salaries for home health aides. Finally the inability to greatly expand the number of primary care physicians has been identified as a challenge to meeting DSRIP goals.

The SI PPS will include recruitment staff and a flexible recruitment strategy for difficult to recruit positions. Cost related to recruitment including head hunter fees and relocation costs have been identified as possible expenses in the workforce budget. The PPS is also considering more innovative approaches to build up the required workforce including working with local colleges, and developing incentive programs to recruit needed staff. Other approaches for consideration include: team based care with levels of expertise and skills ranging from low to high, incorporating varying types of skills and educations levels within titles, and incorporating salary scales or steps to account for the variety of skill set.

***Strategy 3:**

In the table below, please identify the percentage of existing employees who will require re-training, the percentage of employees that will be redeployed, and the percentage of new employees expected to be hired. A specific project may have various levels of impact on the workforce; as a result, the PPS will be expected to complete a more comprehensive assessment on the impact to the workforce on a project by project basis in the immediate future as a Domain 1 process milestone for payment.

Workforce Implication	Percent of Employees Impacted
Redeployment	3%
Retrain	43%
New Hire	3%

Section 5.2 – WORKPLACE RESTRUCTURING - RETRAINING EXISTING STAFF :

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

Description:

Please outline the expected retraining to the workforce.

***Retraining 1:**

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

SI PPS has identified training and retraining as a central component of DSRIP project implementation. SI PPS's approach to training will include: leveraging training resources currently available through the PPS partners/union partners; developing new training resources (including trainers/educators); and leverage training programs that exist outside of the PPS but are pertinent to the PPS goals through training vendor(s) and other resources including the SI's two colleges, the 1199SEIU Training and Employment Fund, Primary Care Development Corporation and Continuing Care Leadership Coalition.

SI PPS will target training to address workforce gaps. Training will serve two purposes: 1) provide baseline process/roles/skills training and 2) facilitate formal certification/licensing training when possible/practical. Training may include:

• Training for Existing staff in new processes and practices: The implementation of a number of the DSRIP projects requires training for current staff that have required technical skills to fulfill their role, but will require training on new care pathways and new processes relevant to DSRIP project goals. This may include on the job training, coaching, classroom training, or web based training, among others. An example specific to the PPS includes educating staff at participating Skilled Nursing Facilities (SNFs) on the INTERACT principles and tools. The SI PPS PAC in conjunction with the Workforce Committee, and PPS partners will develop a training programs or leverage existing programs to provide employees appropriate training. The PPS will need to address the time commitment and resource commitment to train existing staff. This may also include training on health literacy and cultural competency.

• Training for staff redeployed to new locations: The SI PPS recognizes staff currently employed in positions in hospital inpatient units may

require redeployment to outpatient settings. Redeployment of staff will include orienting staff to new positions in new settings, on the job training, coaching, among others. In some instances training staff for new locations may require additional training on new technical skills. In these instances, more intense on the job training and education will be required. The PPS will support redeployed staff that require training through provision of needed training. The PPS strategy will consider the cost of retraining (including cost of training staff and the risk associated with loss of investment should employees that have gone through retraining leave their positions).

• New Positions: The implementation of the 11 DSRIP projects will create new positions that do not currently exist among the SI PPS partners and where staff hired will require training on their new role. An example of this will be the Community Health Workers necessary to implement Project 11 including the addition of multiple staff teams. It is anticipated that training could include intense on the job training, train the trainer and peer training, as well as classroom training. Prior to DY1 and during implementation, the PPS Workforce Strategy will continue to evolve to support ongoing training needs.

The PPS workforce strategy is designed to minimize the negative impact to the workforce, including identifying training and redeployment opportunities. Training for existing staff on new processes and practices required to implement DSRIP projects and meet DSRIP goals will be involuntary, as it is necessary for existing staff to engage in training in the new processes developed by DSRIP projects in order to meet project milestones and DSRIP goals.

***Retraining 2:**

Describe the process and potential impact of this retraining approach, particularly in regards to any identified impact to existing employees' current wages and benefits.

The overall goal of the DSRIP program is to reduce hospital admissions by 25%. In order to accomplish this, there will be a change in care to move patients from the inpatient setting to the ambulatory setting. SI PPS does not envision drastic impacts on current staff. Current collective bargaining agreements provide "job protection" that includes redeployment and continuation of current salaries. If a job posting is not covered under the collective bargaining agreement, then seniority and other language will define and guide the applicable PPS members in the event of retraining or redeployment. Based on this, the PPS estimates 75% of staff will remain at their existing salary level (full placement) while 25% may see an impact on salary (partial placement). For those staff not represented by a collective bargaining agreement that are identified for redeployment, SI PPS will make every effort to match staff skills and education levels to newly created positions so that impact to current salary ranges is minimized.

***Retraining 3:**

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

PPS workforce partners including participating unions, have resources available for staff that refuse their redeployment assignment. For example, 1199 staff that do not qualify or are unable to be retrained to PPS vacancies can utilize the Job Security Fund (JSF) for training or redeployment and would receive priority for existing vacancies within other 1199 New York City facilities. Staff refusing offered positions for which they are qualified for or may be trained to be qualified will lose their benefits (e.g. salary continuation/supplemental unemployment insurance) under JSF. For staff not represented by 1199, Human Resource may assist staff in networking with other facilities with vacancies in the same/similar titles to help facilitate rehire inside or outside of the PPS.

***Retraining 4:**

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

Labor representatives are members of the SI PPS PAC and Workforce Committee. As discussed in Section 2 of the application, the Workforce Committee will oversee the healthcare staff and professional hiring, retention and reallocation within the PPS. Union representatives will be important partners in the implementation of the PPS retraining/redeployment strategy. Further union partners have existing training resources that may be leveraged in the implementation of the PPS Workforce Strategy including the 1199SEIU Training and Employment Fund. Employers with represented staff have established collaboration with the union leadership in developing and implementing training programs that address the changing landscape of healthcare recruitment. There are existing programs that could be utilized to train and enhance the skills of the workforce and support the goals of the PPS. Additionally as identified new programs can and will be developed to meet the needs of the PPS. Whenever possible established programs, services and models that fit and/or enhance programmatic goals will be incorporated.

***Retraining 5:**

In the table below, please identify those staff that will be retrained that are expected to achieve partial or full placement. Partial placement is

defined as those workers that are placed in a new position with at least 75% and less than 95% of previous total compensation. Full placement is defined as those staff with at least 95% of previous total compensation.

Placement Impact	Percent of Retrained Employees Impacted
Full Placement	75%
Partial Placement	25%

Section 5.3 - WORKPLACE RESTRUCTURING - REDEPLOYMENT OF EXISTING STAFF :

Description:
Please outline expected workforce redeployments.

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

The SI PPS envisions the current staff that would be identified for redeployment would be existing inpatient staff at SIUH and RUMC. Through the workforce assessment, both SIUH and RUMC identified, based on expected reduction in inpatient admissions, redeployment may be necessary over time, however many of the staff may be redeployed from inpatient settings at RUMC/SIUH to ambulatory settings. If staff cannot be deployed within outpatient hospital settings, the PPS will work with union partners and PPS partners to identify other appropriate settings.

The preliminary assessment identified of the approximately 8,200 hospital staff, 5% of hospital staff (3% of PPS staff) or 410 staff may be redeployed by DY 5 that will be surplus employees if the PPS reduces inpatient admissions. The PPS also identified approximately 400 new positions required to successfully implement the 11 DSRIP projects. On an ongoing basis the SI PPS will develop a more comprehensive matrix of new position requirements, and potential staff eligible for redeployment. As stated, because the PPS believes the impact on current staff will be felt in the inpatient settings, and that RUMC and SIUH ambulatory programs will expand to support numerous DSRIP projects, much employee matching, e.g. supply vs. demand can be completed without a redeployment to an outside organization. To make the most efficient use of resources the SI PPS will identify the current staffing levels and match it with projections of future needs. This process will help understand the demand and supply of staff across all our partners.
Prior to DY1, the PPS will further assess the impact on the existing workforce. This assessment will be ongoing as the PPS tests the assumptions that were used to measure impact of DSRIP on inpatient admissions, and staff. Employees identified for redeployment will follow the process identified in current collect bargaining agreements. Some redeployment will be done by seniority. Redeployment will consider competency levels, experience levels and PPS needs.

The PPS also envisions some staff, will be interested in redeployment to the new positions created by DSRIP, even without being "identified" for redeployment by reductions in inpatient hospital use. The PPS's redeployment strategy considers those that volunteer for redeployment, or who wish to apply for new positions.

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

SI PPS will make every effort to allow for existing employees to be able to stay within the PPS network. Beginning prior to, and during DSRIP Year 1, the Workforce Committee and will develop a detailed plan that will address the redeployment process, including: detailed comparison between current and future role (e.g. location, salary, benefits, role, responsibility, training, and certification). The PPS anticipate that most employees identified for redeployment will have little to no change in compensation. The Workforce Committee will work with existing HR leads from the various PPS provider entities to identify potential employees for redeployment and the documentation needed to support the redeployment.

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

As previously stated PPS workforce partners/ unions, have resources available for staff that refuse redeployment assignment. SI PPS will follow existing processes in collaboration with union partners for staff redeployment. For example, 1199 staff that do not qualify or are

unable to be retrained to fill PPS vacancies can utilize the Job Security Fund (JSF) for training or redeployment and would receive priority for existing vacancies in other 1199 facilities. Staff refusing positions for which they are qualified or may be trained to be qualified will lose benefits (salary, unemployment insurance) under JSF. For staff not represented by 1199, HR may assist staff in networking with other facilities with vacancies in the same/similar titles to facilitate rehire inside/ outside of the PPS.

***Redeployment 4:**

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

The PPS has included labor representatives within PAC as part of the planning process, and as part of the PAC and the Workforce Committee as part of the Staten Island Performing Provider System, LLC DSRIP implementation strategy. Within the Workforce Committee, and the PAC, labor representatives will have the opportunity to take part in the planning and implementation of workforce strategies, including the redeployment plan. Labor representatives currently have existing processes in place with many of the PPS partners including the PPS leads, these processes around redeployment will be employed for relevant staff in the Workforce Strategy. The PPS will enlist the support of labor representatives in implementing a strategy that minimizes any negative impacts on existing staff and creates new opportunities.

Section 5.4 – WORKPLACE RESTRUCTURING - NEW HIRES :

Description:

Please outline expected additions to the workforce. Briefly describe the new jobs that will be created as a result of the implementation of the DSRIP program and projects.

***New Hires:**

Briefly describe the new jobs that will be created as a result of the implementation of the DSRIP program and projects.

SI PPS has identified approximately 400 new hires to implement DSRIP projects. SI PPS will complete a more comprehensive assessment prior to Demonstration Year 1, however the PPS does foresee a wide range of new positions across the PPS including:

• Administration positions: Provide administrative support to build and expand programs, including Staten Island Performing Provider System, LLC C-suite, general counsel, vice presidents, project director, project managers, recruiters and administrative support

• Ancillary Support Staff: Provide ancillary support for the primary care physicians, specialty physicians, physician assistants and nurse practitioners including clerks, medical assistants and registrars

• Care Manager (RN/Social Worker): Provide care management services such as completing comprehensive care management plans, providing support during care transitions, identifying resource needs, and participating in treatment planning in multidisciplinary care teams

• Certified Alcohol & Substance Abuse Counselors: Support expansion of ambulatory detoxification

• Community Health Workers: Provide culturally competent services to support patients by directing them to services, connect patients to patient navigators/care managers, engaging patients in Patient Activation Measures

• Data Manager/Evaluator/Analysts: Extract/analyze provider and other performance data for reporting and evaluation purposes to support rapid cycle evaluation

• Diabetes Health Educator: Educate patients/providers on diabetes management

• Financial Counseling Staff: Assist patients in obtaining financial assistance/Medicaid eligibility, other insurance

• Information Technology Support: Support the implementation, integration and ongoing maintenance and technical support for SI PPS IT systems

• Licensed Clinical Social Worker: Support the expansion of palliative care and behavioral health integration; participate in are care management and interdisciplinary teams

• Nurse Practitioner: Expand palliative care, behavioral health integration and primary care services in hospital ambulatory providers, community providers, and skilled nursing facilities

• Nutritionist: Support expanded diabetes management, participate in integrated care teams

• Palliative Care Educator: Educate providers/patients on palliative care

• Patient Navigator: Support implementation of care management plan, help patients to "navigate" the delivery system, facilitate linkages to appropriate services, patient education

• Pharmacist: Support care management teams

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• Physician Assistant: Expand palliative care, behavioral health integration and primary care services in outpatient settings and skilled nursing facilities
• Primary Care Physician: Expand primary care services in hospital ambulatory settings, PCMH, FQHC's, physician practices, and behavioral health sites
• Project Clinical Lead/Coordinator: Lead and manage projects along with the Project Director in the PMO
• Psychiatrist: Expand ambulatory detox and behavioral health integration
• Residents: Expand behavioral health integration services at primary care sites and behavioral health sites
• Specialty Physicians: Expand specialty care services to Medicaid low/non utilizers and the uninsured
• Substance Abuse Counselor: Support expansion of ambulatory detoxification services
• Registered Nurse: Support the expansion of primary care, ambulatory detox, etc.
• Nurse Educator/ Trainer/Educator: Educate providers/patients on project related processes, protocols and evidence based practices (e.g. INTERACT)
• Transition Coach: Guide patients to navigate from the inpatient acute care setting to the outpatient setting and to home

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

Position	Approximate Number of New Hires
Administrative	21
Physician	30
Mental Health Providers Case Managers	45
Social Workers	12
IT Staff	10
Other	282

Section 5.5 - Workforce Strategy Budget:

In the table below, identify the planned spending the PPS is committing to in its workforce strategy over the term of the waiver. The PPS must outline the total funding the PPS is committing to spend over the life of the waiver.

Funding Type	DY1 Spend($)	DY2 Spend($)	DY3 Spend($)	DY4 Spend($)	DY5 Spend($)	Total Spend($)
Retraining	3,110,553	3,172,764	3,236,219	3,300,943	3,366,962	16,187,441
Redeployment	442,800	492,000	501,840	511,877	522,114	2,470,631
Recruiting	279,925	234,562	217,849	211,402	211,402	1,155,140
Other	219,835	112,116	67,270	44,846	44,846	488,913

Section 5.6 – State Program Collaboration Efforts:

***Collaboration 1:**

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

The SI understands that the most effective way to begin the implementation of a comprehensive DSRIP strategy is to utilize existing programs where appropriate to support the overall DSRIP goals. The PPS has identified the ability to hire certain staff, including both primary care physicians and psychiatrists, among others, as a challenge to DSRIP project implementation. The PPS Workforce Committee and HR representatives will investigate into the best way to utilize existing state programs including but not limited to: Physician Practice Support, Ambulatory Care Training, and Diversity in Medicine, Support of rea Health Education Centers, and the New York State Health Workforce Retraining Initiative. These existing programs and initiatives can be overlaid with the SI PPS workforce strategy to retrain and redeploy its workforce appropriately to best deliver care and meet the goals of the DSRIP program.

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Section 5.7 - Stakeholder & Worker Engagement:

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

***Engagement 1:**
Outline the steps taken to engage stakeholders in developing the workforce strategy.

Staten Island Performing Provider System, LLC PAC is made up of HR leads and representatives from the various PPS participating providers as well as union representatives. The committee has members representing hospitals, health homes, community based organizations, primary care providers, physicians, mental health providers, among others. The PAC was leveraged during the DSRIP planning process and will be further leveraged, along with the Workforce Committee (that will be a subset of the PAC) in the PPS Management structure to further develop and implement the workforce strategy. Additionally, the PPS held numerous Subcommittee/Workgroup meetings with PPS providers to determine the new staffing requirements related to each DSRIP project as part of the overall workforce strategy. These meetings included representatives from all PPS partners that will be part of DSRIP project plan implemenation.

***Engagement 2:**
Identify which labor groups or worker representatives, where applicable, have been consulted in the planning and development of the PPS approach.

The PPS consulted the following labor groups in the development of the PPS approach: 1199, New York State Nurses Association, Federation of Nurses, and UFT. These labor groups represent a significant portion of the existing workforce within SI PPS. The labor representatives are members in the Project Advisory Committee (PAC). As of the DSRIP application submission, the PAC has been involved reviewing and advising on the high level training, redeployment, and new hires discussions. As described in the Governance section of this application, the PAC's role going forward will include advising the Workforce Committee and the SI PPS, LLC Steering Committee on training and redeployment of existing staff as well as new hires and assisting with implementation of the Workforce Strategy.

***Engagement 3:**
Outline how the PPS has engaged and will continue to engage frontline workers in the planning and implementation of system change.

In addition to our Workforce Committee, the PPS will develop and leverage a Communication and Marketing Committee to develop a communication strategy for frontline workers. The communications strategy will aim to deliver standardized messages across all staffing levels and aims to integrate the front line workers feedback in a consistent manner to enhance collaboration across the entire continuum of care and attain impactful project results. The PPS will leverage surveys, town hall meetings, teleconferences, workgroup meetings, as well comment boxes and virtual comment boxes to gather feedback and exchange information.

***Engagement 4:**
Describe the steps the PPS plans to implement to continue stakeholder and worker engagement and any strategies the PPS will implement to overcome the structural barriers that the PPS anticipates encountering.

The workforce committee will utilize public forums, publicly available website with announcements to inform the community and gain feedback on workforce strategy decisions and plans.

As indicated, the Workforce Committee will work in conjunction with the Communication Committee to develop and implement a comprehensive stakeholder and worker engagement process prior to and throughout DSRIP Year 1; this will include workforce surveys and town hall meetings.

The PPS will integrate the Workforce Committee and the Communication Committee stakeholder engagement processes with current workforce processes including union processes, and human resources processes across the PPS partners to ensure the sustainability overtime.

Section 5.8 - Domain 1 Workforce Process Measures:

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Description:

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

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

☑ Please click here to acknowledge the milestones information above.

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SECTION 6 – DATA SHARING, CONFIDENTIALITY & RAPID CYCLE EVALUATION:

Section 6.0 – Data-Sharing, Confidentiality & Rapid Cycle Evaluation:

Description:
The PPS plan must include provisions for appropriate data sharing arrangements that drive toward a high performing integrated delivery system while appropriately adhering to all federal and state privacy regulations. The PPS plan must include a process for rapid cycle evaluation (RCE) and indicate how it will tie into the state's requirement to report to DOH and CMS on a rapid cycle basis.

This section is broken into the following subsections:
- 6.1 Data-Sharing & Confidentiality
- 6.2 Rapid-Cycle Evaluation

Scoring Process:

This section is worth 5% of the total points available for the Overall PPS Structure Score. The responses will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.
- 6.1 is worth 50% of the total points available for Section 6.
- 6.2 is worth 50% of the total points available for Section 6.

Section 6.1 – Data-Sharing & Confidentiality:

Description:
The PPS plan must have a data-sharing & confidentiality plan that ensures compliance with all Federal and State privacy laws while also identifying opportunities within the law to develop clinical collaborations and data-sharing to improve the quality of care and care coordination. In the response below, please:

***Confidentiality 1:**
Provide a description of the PPS' plan for appropriate data sharing arrangements among its partner organizations.

Staten Island (SI) PPS' data sharing plan will maintain and balance the security and privacy of patient data while ensuring collaboration and sufficient data sharing and connectivity between partners to meet DSRIP goals. The Data/IT and Compliance Committees will develop data sharing arrangements for SI PPS partners for recommendation and approval by the Steering Committee and Board. The PMO will support the implementation of the data sharing arrangements. Arrangements will ensure compliance with all NYS, HIPAA and relevant federal regulations. Also the PMO with oversight from the Data/IT and Compliance Committees will perform periodic internal audits on adherence to SI PPS' Data/IT procedures.

SI PPS partners have a wide range of in-house IT capabilities, SI PPS plans to use appropriate data sharing methods to accommodate paper based organizations and those without EMR capabilities. In the long term, the PPS anticipates the partners to upgrade and follow data sharing standards.

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

SI PPS Data/IT and Compliance Committees will develop data collection, retention, and sharing policies, as well as a training program to ensure compliance with regulations across the PPS. Currently, the PPS Co-Leads and partners have standards regarding data privacy/security and HIPAA compliance (including training programs and breach mitigation strategies) to be utilized and expanded on for the PPS. PPS partners are required to agree to the policies as they relate to information sharing through the DSRIP program. Also partners will be required to obtain the appropriate patient consent to share and access data among providers. All partners will also sign a Business Associates Agreement (BAA) pursuant to HIPAA regulations. The Data/IT Governance Committee and PMO will be responsible for the implementation and monitoring of all such agreements. Patient consent will be monitored and maintained through participation and collaboration with the SI RHIO and participating providers.

***Confidentiality 3:**

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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.

SI PPS Data/IT and Compliance Committees will develop data collection, retention, and sharing policies, as well as a training program to ensure compliance with regulations across the PPS. Currently, the PPS Co-Leads and partners have standards regarding data privacy/security and HIPAA compliance (including training programs and breach mitigation strategies) to be utilized and expanded on for the PPS. PPS partners are required to agree to the policies as they relate to information sharing through the DSRIP program. Also partners will be required to obtain the appropriate patient consent to share and access data among providers. All partners will also sign a Business Associates Agreement (BAA) pursuant to HIPAA regulations. The Data/IT Governance Committee and PMO will be responsible for the implementation and monitoring of all such agreements. Patient consent will be monitored and maintained through participation and collaboration with the SI RHIO and participating providers.

Section 6.2 – Rapid-Cycle Evaluation:

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

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

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

The PMO is responsible for executing the rapid-cycle evaluation strategy developed by the Staten Island Performing Provider System, LLC governance committees. The PMO will employ data managers/analysts to collect, analyze and report data. Project managers/coordinators will drive and implement plans to meet outcomes. The PMO will execute recommendations of the committees with approval from the Steering Committee (SC) and Board. The Data/IT Committee will ensure the IT infrastructure is in place to support rapid cycle evaluation.

The Clinical Committee will develop and monitor performance on clinical standards at the provider level to pro-actively identify areas of risk and/or underperforming providers. The Finance Committee (FC) will monitor financial metrics. The SC will identify other non-clinical/non-financial metrics relevant to DSRIP goals to be collected/tracked related to provider operations, quality, safety and patient satisfaction. Data tracked and collected by the PMO will be reported to the committees for review. Collaboratively, governance committees will work with poor performing providers to design corrective action plans, provide support and evaluate improvement.

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

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

The Steering, Clinical, and Finance Committees will develop and define clear DSRIP goals/expectations for each PPS partner and will continuously evaluate the partners' performance based on the goals/expectations. This process will begin prior to Demonstration Year (DY) 1.

The PMO will collect provider performance data on an ongoing basis and complete performance assessments based on the established goals. PPS partners will be expected to contribute key data to the PMO in defined formats. The PMO will develop performance dashboards and report to the governance committees and Board to identify poor performing providers and/or projects and develop performance improvement plans.

The ability to complete population health analytics and risk stratify the population is critical for success. The PPS will leverage claims data

and other available data to develop patient registries and perform risk stratification using existing population health management tools or purchased tools.

***RCE 3:**

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

The PMO will include project managers and data analytics staff responsible for collecting, analyzing and reporting data in a standardized format to the governance committees and Board. The PMO will utilize existing/purchased technology to produce Performance Management Dashboard tools to facilitate the interpretation and reporting of data collected at the project and provider level. Collected data will include patient outcomes metrics, provider/clinical performance metrics, financial metrics, and other performance metrics, to measure, report, and manage PPS providers. To address this in the short term, the PMO will develop performance management dashboards to initiate reporting. Performance dashboards will identify underperforming providers to initiate a performance improvement plan development in conjunction with the appropriate governance committees. Performance dashboards will also be shared with PPS provider members for review and input.

***RCE 4:**

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

Performance management will be a fundamental component in transforming the PPS into a highly functioning network of providers serving the SI population. The PPS will use RCE in the timely identification of necessary changes and recommendations to keep the projects on track as well as facilitate the efficient implementation of required changes.

RCE will allow the PPS to continuously respond to performance outcomes with program changes, including sharing best practices across PPS members for providers and programs meeting or exceeding goals, and rapidly modifying clinical and process standards as needed to drive improvement where the PPS or a specific provider requires it. The PPS will incentivize providers through funds flow (as describes in Section 8) including rewarding providers for meeting/exceeding performance standards, and penalizing providers that have continuously failed to meet established performance goals.

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SECTION 7 – PPS CULTURAL COMPETENCY/HEALTH LITERACY:

Section 7.0 – PPS Cultural Competency/Health Literacy:

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

This section is broken into the following subsections:
- 7.1 Approach To Achieving Cultural Competence
- 7.2 Approach To Improving Health Literacy
- 7.3 Domain 1 - Cultural Competency / Health Literacy Milestones

Scoring Process:

This section is worth 15% of the total points available for the Overall PPS Structure Score. The responses will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.
- 7.1 is worth 50% of the total points available for Section 7.
- 7.2 is worth 50% of the total points available for Section 7.
- 7.3 is not valued in points but contains information about Domain 1 milestones related to these topics which must be read and acknowledged before continuing.

Section 7.1 – Approach to Achieving Cultural Competence:

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

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

***Competency 1:**
Describe the identified and/or known cultural competency challenges which the PPS must address to ensure success.

Staten Island (SI) is comprised of an ethnically diverse population, presenting linguistic and cultural barriers for Medicaid enrollees and the uninsured attempting to self-manage care and access and navigate the healthcare system. As identified by the Community Needs Assessment (CNA), 30% of SI's population speaks a language other than English at home, higher than the New York State average. The Asian/Pacific Island population maintain the lowest levels of English proficiency, followed by the Indo-European and Spanish speaking population. Across all non-English speaking populations, the aging population, those 65 or older, have the lowest English proficiency levels. SI's highest number of Medicaid enrollees is attributed to its White population (37.6%) followed by its Hispanic (26.5%), African American (15.7%) and Asian/Pacific Islander population (8.7%). SI's population has a lower percentage of residents with high school degrees compared to the New York State (NYS) average, created additional challenges around health literacy. Additionally, SI's estimated poverty level is measured at 13.7% and per capital income is on average, lower than the NYS average (US Census data).

SI's economically and ethnically diverse community has health disparities and barriers to accessing care, especially for individuals living in communities on the North Shore of SI (ZIP codes in the northern part of SI are commonly referred to as the North Shore). SI's North Shore Medicaid population has hospitalization rates higher than the NYS average as well as other SI communities, (CNA), with the North Shore population representing the majority of SI's Medicaid population.

Further, currently, there is limited cultural competency and sensitivity training for healthcare workers in the Staten Island Performing

Provider System (SI PPS) and SI PPS providers identified access to linguistically appropriate healthcare services as a gap on SI.

***Competency 2:**

Describe the strategic plan and ongoing processes the PPS will implement to develop a culturally competent organization and a culturally responsive system of care. Particularly address how the PPS will engage and train frontline healthcare workers in order to improve patient outcomes by overcoming cultural competency challenges.

Cultural competency and health literacy are two components of 'Diversity and Inclusion' which ensure that healthcare providers and patient populations work together through a shared knowledge, acceptance and awareness of differences in behaviors, health-related beliefs and needs with the overarching goal of improving health and wellness. SI's diverse population includes racial and ethnic groups, LGBT, military, elderly, and those with disabilities as well as a wide range of health disparities. Improving the SI PPS's cultural competency will increase patient engagement, access to care, patient safety, reduce disparities and adverse events, and improve patient outcomes.

As part of the SI PPS's strategic/program plan, a Diversity and Inclusion Committee will serve in the overall management structure and advise the Steering Committee, Board and Project Management Office. Committee members will meet monthly and provide guidance for project implementation. The Committee's Members or "Champions" will include representatives from the SI PPS and Community-Based Organizations (CBO), such as the Staten Island Immigrants Council. Champions will be responsible for the development of policies and initiatives including training, continuing education workshops, and distribution of materials for healthcare workers as well as data collection and reporting at each site. Cross cultural staff training programs will be developed specific to the needs of each site and communities served. Training programs will be continually updated as demographics evolve to ensure that healthcare settings and services remain culturally appropriate. The SI PPS will also utilize data collected during the initial community assessment to develop culturally competent services and programs. Additionally, the SI PPS will also conduct a baseline survey of healthcare workers to measure and identify workforce diversity (needs, interests, and capabilities) at each PPS provider and participating CBO site.

***Competency 3:**

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

As needed, the SI PPS will partner with or contract with community-based organizations to assist in the development and execution of Diversity and Inclusion policies and initiatives developed by Diversity and Inclusion Committee Members, in conjunction with the Steering Committee and Workforce Committee, among others. The Diversity and Inclusion Committee, with the support of the PMO, will perform an initial assessment of partnered or contracted community-based organizations to identify and analyze gaps in training/cultural competencies and work with community-based organizations to integrate health literacy curriculums into their service models. One project where these goals are specifically pertinent is for Project 2di. "Project 11" where cultural competency is an important training component for individuals that will be trained in Patient Activation Members (PAM) and performing outreach services. The SI PPS will leverage CBOs in executing "Project 11" goals and achieving cultural competency.

Section 7.2 – Approach to Improving Health Literacy:

Description:

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

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

***Literacy:**

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

- Describe the PPS plan to improve and reinforce the health literacy of patients served.

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

The SI PPS acknowledges that clear communication of healthcare information and advancing/ reinforcing health literacy skills will improve patient health outcomes including accessing covered services, adherence to medication and treatment, management of illnesses, and decreased lengths of stay, emergency department use, and readmissions. Overall this improves patient provider interaction and satisfaction scores.

SI's population speaks over 158 languages; approximately 30% of the population speaks a language other than English at home, and faces language barriers due to limited health literacy. Further, 1 in 5 English speakers read below a 5th grade reading level and nearly half of all English speakers have low health literacy.

The SI PPS recognizes these barriers for both English and non-English speakers. To address these challenges, the SI PPS will utilize a partner-centric approach of shared responsibility to improve health literacy between patients and healthcare providers. As part of this approach, the SI PPS is committed to enhancing providers' ability to communicate in plain language, improve language access services and reinvigorate the Healthy Partnerships' Health Literacy Program through the DSRIP projects. The SI PPS will also develop additional health literacy initiatives based on best practices and implement the initiatives through the Diversion and Inclusion Committee, in conjunction with the Steering Committee and PMO.

The following provides a high level overview of the initiatives that will be pursued by the SI PPS and the Diversity and Inclusion Committee to promote health literacy: (1) Develop and share health literacy simple language, verbal and written communication and language access policies to all participating PPS providers; (2) Require SI PPS providers to attend annual training on communication and health literacy. Topics will include the application of universal health literacy principles, the teach back method, reliable electronic resources, working with a qualified medical interpreter, and accessing translated material; and (3) Increase the use of and access to language services through the expansion of the Dual-Role Medical Interpreter training program, video remote and telephonic interpreting, and the dissemination of translated materials.

As needed, the SI PPS will partner with or contract with community based organizations (CBO) to achieve and maintain health literacy throughout the DSRIP projects. To achieve this, the SI PPS will work with CBO's to train frontline workers to assess health literacy in order to gauge learning style, language barriers, literacy barriers, and appropriate services needed. The PPS will also incorporate health literacy curriculum from the Healthy Partnership program into services provided by CBOs and ensure CBO's are meeting PPS standards and policies.

Section 7.3 - Domain 1 – Cultural Competency/Health Literacy Milestones :

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

- Report on the development of training programs surrounding cultural competency and health literacy; and
- Report on, and documentation to support, the development of policies and procedures which articulate requirements for care consistency and health literacy.

Please click here to acknowledge the milestones information above.

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SECTION 8 – DSRIP BUDGET & FLOW OF FUNDS:

Section 8.0 – Project Budget:

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

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

Scoring Process:

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

Section 8.1 – High Level Budget and Flow of Funds:

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

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

The Staten Island Performing Provider System, LLC (SI PPS, LLC) plans to distribute funds based on the costs project implementation, cost of previously not covered or under-reimbursed services, bonus payments, and revenue loss. To initially address funds distribution, the PPS has developed preliminary budgets to estimate project implementation and Project Management Office (PMO) costs. The budgets for the projects and PMO will be further refined prior to Demonstration Year 1.

The cost of services and programs not previously reimbursable and/or covered by Medicaid (e.g. telehealth and mobile vans) will receive an allocation of DSRIP funds to cover the costs of providing services relevant to achieving project specific metrics and goals. Allocations will be established based on the estimated costs and volume of specific services.

The SI PPS, LLC will establish bonus payments to incentivize PPS providers to meet and exceed PPS established quality metrics and outcome standards. Funds will be distributed based on evidence that a provider has met specific milestones (achieving PCMH 2014 NCQA Level 3 designation, implementing INTERACT, or integrating with the RHIO, Healthix) to incentivize providers.

The SI PPS, LLC will provide revenue loss payments to mitigate the loss of funding due to the reduction of inpatient services at Staten Island University Hospital and Richmond University Medical Center.

Project implementation funding covers operating costs incurred by a PPS partners to specifically deliver and execute services under the DSRIP projects that cannot be reimbursed through traditional reimbursement mechanisms. Funding includes SI PPS, LLC costs (PMO, related salaries, and operating expenses).

The SI PPS, LLC will also hold contingency funds for unforeseeable events.

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The PPS will develop budgets specific to each provider type to fully capture project implementation costs. At the provider level, the SI PPS, LLC will determine funds flow allocation per provider, based on the extent to which they are supporting project goals, across Federally Qualified Health Centers, Skilled Nursing Facilities, substance abuse and behavioral health providers, and hospital ambulatory providers, among others. The funds will cover expenses to develop and expand programs/services as well as cover program/service costs that are not reimbursable through traditional methods.

At a governance level, as described in Section 2 (Governance), the SIPPS, LLC Finance Committee will oversee the financial management processes including fund allocation, distribution, reporting, status monitoring, budgeting, and compliance. The Finance Committee will coordinate and execute the described tasks through the PMO. Specifically, the Finance Committee is responsible for the receipt and distribution of funds to PPS partners and the SIPPS, LLC. The Finance Committee will distribute funds according to the funds flow protocols established by the SIPPS, LLC. Board, with advisement from the Steering Committee. The Steering Committee, which is made up of PPS providers, will ensure that DSRIP funds flow to PPS providers is specific to achieving DSRIP goals.

Further, the PPS plans to utilize the Finance Committee and Clinical Committee, in conjunction with the PMO, to perform regular assessments of PPS providers and report progress to the Steering Committee and Board on whether PPS providers will meet/exceed project goals.

As the PPS continues to evolve, the PPS reserves the right to adjust the described funds flow methodology accordingly. If modifications are required, however, the Steering Committee will advise the Board in order to receive approval for any changes.

Section 8.2 – Budget Methodology:

***Budget 2:**
To summarize the methodology, please identify the percentage of payments the PPS intends to distribute amongst defined budget categories. Budget categories must include (but are not limited to):

- Cost of Project Implementation: the PPS should consider all costs incurred by the PPS and its participating providers in implementing the DSRIP Project Plan.
- Revenue Loss: the PPS should consider the revenue lost by participating providers in implementing the DSRIP Project Plan through changes such as a reduction in bed capacity, closure of a clinic site, or other significant changes in existing business models.
- Internal PPS Provider Bonus Payments: the PPS should consider the impact of individual providers in the PPS meeting and exceeding the goal of the PPS' DSRIP Project Plan.

Please complete the following chart to illustrate the PPS' proposed approach for allocating performance payments. Please note, the percentages requested represent aggregated estimated percentages over the five-year DSRIP period; are subject to change under PPS governance procedures; and are based on the maximum funding amount.

#	Budget Category	Percentage (%)
1	Cost of Project Implementation	40%
2	Revenue Loss	15%
3	Internal PPS Provider Bonus Payments	25%
4	Cost of Previously Not Covered or Under-Reimbursed by Medicaid	10%
5	Cointengency Fund	10%
	Total Percentage:	100%

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

Description:
Progress towards achieving the project goals and core requirements specified above will be assessed by specific milestones for the DSRIP

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

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

☑ Please click here to acknowledge the milestones information above.

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SECTION 9 – FINANCIAL SUSTAINABILITY PLAN:

Section 9.0 – Financial Sustainability Plan:

Description:
The continuing success of the PPS' DSRIP Project Plan will require not only successful service delivery integration, but the establishment of an organizational structure that supports the PPS' DSRIP goals. One of the key components of that organizational structure is the ability to implement financial practices that will ensure the financial sustainability of the PPS as a whole. Each PPS will have the ability to establish the financial practices that best meet the needs, structure, and composition of their respective PPS. In this section of the DSRIP Project Plan the PPS must illustrate its plan for implementing a financial structure that will support the financial sustainability of the PPS throughout the five year DSRIP demonstration period and beyond.

This section is broken into the following subsections:
- 9.1 Assessment of PPS Financial Landscape
- 9.2 Path to PPS Financial Sustainability
- 9.3 Strategy to Pursue and Implement Payment Transformation to Support Financial Sustainability
- 9.4 Domain 1 - Financial Sustainability Plan Milestones

Scoring Process:

This section is worth 10% of the total points available for the Overall PPS Structure Score. The responses will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.
- 9.1 is worth 33.33% of the total points available for Section 9.
- 9.2 is worth 33.33% of the total points available for Section 9.
- 9.3 is worth 33.33% of the total points available for Section 9.
- 9.4 is not valued in points but contains information about Domain 1 milestones related to Financial Sustainability which must be read and acknowledged before continuing.

Section 9.1 – Assessment of PPS Financial Landscape:

Description:
It is critical for the PPS to understand the overall financial health of the PPS. The PPS will need to understand the providers within the network that are financially fragile and whose financial future could be further impacted by the goals and objectives of DSRIP projects. In the narrative, please address the following:

***Assessment 1:**
Describe the assessment the PPS has performed to identify the PPS partners that are currently financially challenged and are at risk for financial failure.

The Staten Island PPS (SI PPS) is aware of the critical impact each providers' financial health will have on the overall system. To understand the financial stability of each provider, the SI PPS issued a financial assessment and financial data request to its PPS provider partners. The review of the data requested and completed financial assessment enables the PPS Co-leads to review the financial sustainability of each participating provider to determine the viability of the PPS partners as it relates to successfully implementing the DSRIP projects. Each of the PPS participating providers was asked to provide the following information: financial ratios (e.g. current ratio, days cash on hand, debt ratio, debt service ratio, operating margin and total margin), volume and revenue information for commercial, Medicare Fee-for-Service, Medicare Managed Care, Medicaid Fee-for-Service and Medicaid Managed Care, as well as audited financial statements (or internal financial statements reviewed by the organizations governing body), as well as cost reports if available. The information was provided for 2012, 2013 and 2014 year to date for review by the Co-Lead financial organizations (Chief Financial Officers). The Co-Lead CFO's are in the process of reviewing the data collected including identifying any at risk providers or relevant findings to be reported to the DSRIP Steering Committee and Board prior to Demonstration Year 1 and prior to funds distribution.

***Assessment 2:**
Identify at a high level the expected financial impact that DSRIP projects will have on financially fragile providers and/or other providers that could be negatively impacted by the goals of DSRIP.

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The PPS completed an assessment of the impact of the DSRIP program based on the expected reduction of avoidable hospitalizations and emergency department visits that would result from meeting DSRIP project goals; as well as the impact delivery system reforms would have on other providers. The assessment identified that the direct financially impact associated with reduction in inpatient use would be on the two inpatient acute hospital providers on SI, Richmond University Medical Center (RUMC) and Staten Island University Hospital (SIUH) both of which will see a reduction in admissions and ED visits.

DSRIP implementation will have additional impacts on the financial performance of PPS providers, with greater impacts being felt those providers already deemed to be financially fragile. As DSRIP payments are performance based, if a provider fails to meet DSRIP goals after making investments in DSRIP project implementation, they may be negatively impacted financially by a performance based payment system.

Finally, a number of SI PPS providers have traditionally received support payments from the State, Grant programs, and other funding that is expected to be reduced through the DSRIP implementation, the PPS foresees those providers who have traditionally relied upon these funds will be negatively impacted by DSRIP implementation.

The following provides an overview of how DSRIP projects could potentially impact providers:

• Reductions in admissions and ED volumes may directly impact acute care providers until these providers and PPS transitions to a value-based payment system.
• Loss of support payments, including State funds and grant funding, particularly for disproportionate share providers.
• Costs associated with lost productivity, and/or costs for "backfilling" positions during DSRIP related training.
• Short term costs may rise as it relates to the discontinuation and elimination of certain services are required by project goals.
• Costs associated with PPS performance based payments for providers that do not meet DSRIP related milestones and/or goals either initially or in the long term and thus do not receive maximum approved PPS DSRIP funds (and may have incurred implementation costs)
• The timing associated with fund distribution: DSRIP implementation timelines may require a PPS provider to make investments prior to the receipt of DSRIP funds. This may negatively impact these providers in the short term.

SI PPS understands the importance of properly supporting all PPS providers in the implementation of DSRIP goals, and has made provision in the funds flow plan to provide this support for providers particularly the safety net providers through cost of implementation funds, bonus payments, and funds for cost of previously not covered or under reimbursed services.

Section 9.2 – Path to PPS Financial Sustainability:

Description:
The PPS must develop a strategic plan to achieve financial sustainability, so as to ensure all Medicaid members attributed to the PPS have access to the full ranges of necessary services. In the narrative, please address the following:

***Path 1:**
Describe the plan the PPS has or will develop, outlining the PPS' path to financial sustainability and citing any known financial restructuring efforts that will require completion.

In the short term, the SI PPS will utilize the results of the PPS financial sustainability assessment and the ongoing review of provider financial performance to identify at risk providers and develop interventions as needed through DSRIP funds flow. The SI PPS's long term strategy to achieve financial sustainability will be through the transition from Fee-for-Service payments to a Value-Based payment structure by Demonstration Year 5 that emphasizes population outcomes.

Prior to DSRIP Year 1, the Staten Island Performing Provider System, LLC (SI PPS, LLC) Finance Committee, in conjunction with the Steering Committee will develop a short and long term plan towards financial sustainability to be implemented by the project management office (PMO) and approved by the Steering Committee and Board. The PPS will revisit the plan on an ongoing basis to assess any needed modifications. This will include defining metrics to assess financial sustainability and a process to collect and report on those metrics. Measures of financial sustainability will align with metrics to measure DSRIP performance as they relate to the achievement of DSRIP milestones and metrics. This process will be part of the overall rapid cycle evaluation process referenced in Section 6. Providers identified as at risk will be reported to the Steering Committee for the development of corrective actions and interventions.

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The SI PPS will maintain financial sustainability by transitioning to payment structures that emphasize population outcomes. The SI PPS will first focus on developing an infrastructure to build a population focused integrated delivery system by investing in expanding provider capacity including an enhanced care management model; training; information technology and community based supports during the initial DSRIP years.

In later DSRIP implementation years, the PPS will consider a stepped approach to implementing value based payment arrangements including shared savings models.

The PPS is not currently aware of any necessary restructuring efforts. The PPS Finance Committee and Steering Committee will continue to assess and monitor financial performance based on established metrics.

***Path 2:**

Describe how the PPS will monitor the financial sustainability of each PPS partner and ensure that those fragile safety net providers essential to achieving the PPS' DSRIP goals will achieve a path of financial sustainability.

As part of the PPS management structure, the SI PPS, LLC will have a CFO and support staff, as well as a Finance Committee tasked with monitoring the financial sustainability of each PPS partner, including fragile safety net providers participating in DSRIP projects in achieving financial sustainability. The PPS, in conjunction with the Finance and Steering Committee will develop an implementation plan early in Demonstration Year 1 (DY 1) to support PPS providers in the short and long term through the transition to value based payment. The SI PPS, LLC Finance Committee in conjunction with other governance committees will assess the financial performance of SI PPS providers, as well as their performance in meeting DSRIP metrics and milestones. The PMO will collect needed data and report performance in standard dashboards to the governance committees. Performance will be reported to the Steering Committee and Board. As needed, the SI PPS, LLC will work collaboratively with the provider to improve their financial performance by developing performance improvement plans approved by the Steering Committee and Board.

***Path 3:**

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

Critical components of the SI PPS' DSRIP implementation including strategically investing in an information technology (IT) infrastructure, population health analytics and community based supports will enable the PPS to sustain DSRIP outcomes at the conclusion of the program. The PPS will develop a care delivery system that is driven by outcomes and overall costs of care, and grounded in evidence based practices. This will serve as the foundation for the transition to a delivery system and payment structure that emphasizes population health outcomes, allowing the PPS to maintain financial sustainability post DSRIP. Provider partners that initially receive funding for project implementation expenses, meeting/exceeding project milestones, and payment for unreimbursable services will eventually be able to enter into value based payment arrangements based on these principles.

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

Description:

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

***Strategy 1:**

Articulate the PPS' vision for transforming to value based reimbursement methodologies and how the PPS plans to engage Medicaid managed care organizations in this process.

DSRIP is designed to promote the sustainable and systemic modifications needed for providers to implement change that will allow patients to receive better care. The SI PPS will work to ensure that SI's Medicaid patients have access to the full range of services that the population requires and that these services are sustainable. The PPS has begun conversations around financial sustainability with SI's largest MCOs and will continue these discussions into DY1 to develop a value based reimbursement (VBR) strategy. Members of the PPS have experience with VBR arrangements including bundled payment models, capitation agreements, and shared savings that will be leveraged in the development of an approach.

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The PPS envisions implementing a phased approach through one or more of the following payment arrangements: shared savings, bundled payments, and pay for performance. The first step in developing the capacity to enter into VBR will be developing the infrastructure to measure and report patient and provider metrics. Shared savings models can provide incentives for health care providers that agree to work together and become accountable for coordinating care to the Medicaid population, similar to the DSRIP bonus payments and other DSRIP funds that may be used to incentivize providers in the short term.

The SI PPS will continue to assess and measure progress towards VBR payment and implement practices that will best prepare the PPS on an ongoing basis.

***Strategy 2:**

Outline how payment transformation will assist the PPS to achieve a path of financial stability, particularly for financially fragile safety net providers

The reduction in avoidable admissions and emergency department visits (high cost inpatient services) expected to be achieved through the SI PPS DSRIP projects aimed at reducing acute transfers, reducing 30 day readmissions, and reducing inpatient detox admissions, among others, will drive down the overall cost of care for Medicaid patients (per member per month costs). Additionally, projects focused on expanding palliative care, and strengthening the home care infrastructure will aim to reduce the costs associated with end of life care (caring for Medicaid patients over 85) where the PMPM costs far exceed PMPM costs for other age groups. In the short term, this reduction in revenue for acute care providers will be supplemented by DSRIP funds, however in the long term a transition to a patient focused/total cost of care reimbursement model will create a path toward financial sustainability. The DSRIP bonus payments provide incentives that drive providers to reduce the overall costs of care and drive appropriate utilization of services in the short term. In the long term this can be achieved through shared savings models, where PPS providers, the MCO's and DOH share in the overall savings associated with most efficiently treating the patient at the right time, for the right cost, in the right place (including providing lower cost prevention and management in outpatient settings and avoiding inpatient admissions).

Additional options for the PPS are bundle payment models where the PPS will be able to receive bundle payments for services, including chronic disease management such as diabetes, where the PPS providers receive annual payments to care for a patient with a chronic illness.

The SI PPS has already initiated discussion with MCOs around the transition to value based reimbursement and will continue discussions to specifically develop reimbursement models to support PPS providers, particular fragile safety net providers.

Section 9.4 - Domain 1 – Financial Sustainability Plan Milestones:

Description:

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

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

Please click here to acknowledge the milestones information above.

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SECTION 10 – BONUS POINTS:

Section 10.0 – Bonus Points:

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

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

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

Both PPS co-leaders, Richmond University Medical Center and Staten Island University Hospital bring significant population health management experience to the DSRIP Staten Island PPS. Richmond University Medical Center has significant experience in obtaining and operating NCQA certified Patient Centered Medical Home care. In June 2014, RUMC ambulatory care practices in Pediatrics and Adult Primary care received PCMH level certification from NCQA. The medical home is best described as a model or philosophy of primary care that is patient-centered, comprehensive, team-based, coordinated, and focused on population health management, quality and safety. It is a philosophy of health care delivery that encourages providers and care teams to meet patients where they are, from the most simple to the most complex conditions. There are over 10,000 unique patients that are now the focus of this population health platform. Care is coordinated throughout the continuum incorporating all testing, referrals, and lab results and management across disease conditions.
Staten Island University Hospital is a part of the North Shore-LIJ Health System. As a co-lead, this will enable the SI PPS to utilize the System's management capabilities. NSLIJ has full/shared risk and shared savings contracts with Medicaid and commercial payers, for over 250,000 lives. Programs include Independence at Home (1 of 18 national MSSP demonstration sites targeting high risk seniors); Bundled Payment for Care Improvement (hospital-physician full-risk, care arrangement targeting high risk/high spend conditions including Stroke, Valve Replacement and CABG); and Care Solutions (organization dedicated to facilitating physician and hospital collaboration with post-acute entities). NSLIJ built the CareConnect insurance company. In January 2015, CareConnect will receive a "FIDA" license to test a new model for providing "Dual Eligible" enrollees with a more coordinated, person-centered care experience.

Proven Workforce Strategy Vendor (PWSV):
Minimizing the negative impact to the workforce to the greatest extent possible is an important DSRIP goal. If applicable, please outline whether the PPS has or intends to contract with a proven and experienced entity to help carry out the PPS' workforce strategy of retraining, redeploying, and recruiting employees. Particular importance is placed on those entities that can demonstrate experience successfully retraining and redeploying healthcare workers due to restructuring changes.

The reduction in avoidable admissions and emergency department visits (high cost inpatient services) expected to be achieved through the SI PPS DSRIP projects aimed at reducing acute transfers, reducing 30 day readmissions, and reducing inpatient detox admissions, among others, will drive down the overall cost of care for Medicaid patients (per member per month costs). Additionally, projects focused on expanding palliative care, and strengthening the home care infrastructure will aim to reduce the costs associated with end of life care (caring for Medicaid patients over 85) where the PMPM costs far exceed PMPM costs for other age groups. In the short term, this reduction in revenue for acute care providers will be supplemented by DSRIP funds, however in the long term a transition to a patient focused/total cost of care reimbursement model will create a path toward financial sustainability. The DSRIP bonus payments provide incentives that drive providers to reduce the overall costs of care and drive appropriate utilization of services in the short term. In the long term this can be achieved through shared savings models, where PPS providers, the MCO's and DOH share in the overall savings associated with most efficiently treating the patient at the right time, for the right cost, in the right place (including providing lower cost prevention and management in outpatient settings and avoiding inpatient admissions).

Additional options for the PPS are bundle payment models where the PPS will be able to receive bundle payments for services, including chronic disease management such as diabetes, where the PPS providers receive annual payments to care for a patient with a chronic illness.

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The SI PPS has already initiated discussion with MCOs around the transition to value based reimbursement and will continue discussions to specifically develop reimbursement models to support PPS providers, particular fragile safety net providers.

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

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SECTION 11 – ATTESTATION:

Attestation:

The Lead Representative has been the designated by the Lead PPS Primary Lead Provider (PPS Lead Entity) as the signing officiate for the DSRIP Project Plan Application. The Lead Representative has the authority to complete this attestation on behalf of the PPS network. The Lead Representative and the Lead PPS Primary Lead Provider are responsible for the authenticity and accuracy of the material submitted in this application.

The Lead Representative of the Performing Provider System (PPS) must complete this attestation form in order for the project application to be Accepted by the NYS Department of Health. Once the attestation is complete, the application will be locked from any further editing. Do not complete this section until your entire application is complete.

If your application was locked in error and additional changes are necessary, please use the contact information on the Organizational Application Index/Home Page to request that your application be unlocked.

To electronically sign this application, please enter the required information and check the box below:

☑ ***I hereby attest as the Lead Representative of this PPS Richmond Univ Med Center & Staten Island Univ Hosp that all information provided on this Project Plan Applicant is true and accurate to the best of my knowledge.***

Primary Lead Provider Name: STATEN ISLAND UNIV HOSP
Secondary Lead Provider Name: RICHMOND UNIVERSITY MED CTR

Lead Representative:	Joseph G Conte
Submission Date:	12/22/2014 04:43 PM

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