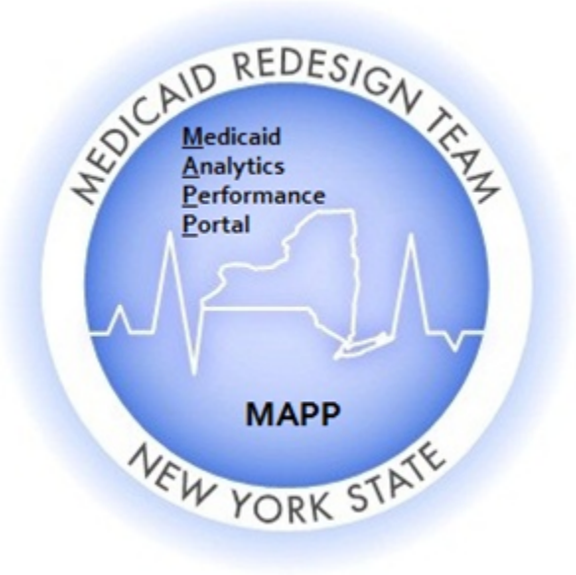
New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP PPS Organizational Application



Stony Brook University Hospital

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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: **16_SEC000_DSRIP Financial Stress Test.pdf**

Description of File

Financial Stress Test

File Uploaded By: lucykenn
File Uploaded On: 12/18/2014 06:31 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: lucykenn
Last Updated On: 12/22/2014 12:05 PM

Certified By: garybie
Certified On: 12/22/2014 02:58 PM
Lead Representative: Gary Bie

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 a robust data infrastructure and advanced analytical capabilities.	A health information exchange (HIE) across PPS partners is essential for effective care coordination and management. A key objective will be to assure that all PPS partners have electronic medical records (EMR) that feed disease registries, clinical decision support systems, predictive models, and other analytic software. This includes assuring that providers have timely access to claims-based data (particularly for ED visits), and the ability to translate information into care management activities. We will manage subsets of high need, high cost patients with personalized approaches and will use predictive modeling to identify patients at risk for decompensation so that we can address their needs proactively and monitor population-based parameters.
2	Improve access to care, particularly for Medicaid members and uninsured populations.	Access to comprehensive, quality healthcare services is important for achieving health equity and for promoting better overall quality of life. Healthcare access impacts overall physical, social and mental health status; prevention of disease and disability; detection and treatment of health conditions; preventable death; and life expectancy. Access to health services means the timely use of personal health services to achieve the best health outcomes. It requires gaining entry into the healthcare system; accessing a healthcare location where needed services are provided; and finding a healthcare provider that the patient can trust and with whom the patient can communicate.
3	Improve disease management, particularly for those with chronic disease.	Chronic disease is highly prevalent in Suffolk County and costly to manage. Deficiencies in disease management include: rushed practitioners not following established practice guidelines; lack of care coordination; lack of active follow-up to ensure the best outcomes; and the fact that patients are often inadequately trained to manage their illnesses. Preventing chronic disease and impacting morbidity and mortality from chronic conditions can be enhanced by adopting strategies that integrate population health and the social determinants of health into chronic care models, along with realigning the patient-physician relationship and effectively engaging providers across the continuum within the communities they serve.
4	Move providers away from the traditional fee-for-service payment and toward value based payment.	This goal will include cooperating with payers in developing a broad set of performance-based payment strategies that link financial incentives to providers' performance on a set of defined measures. This will not only improve the quality of care, but also it will lead to better value by driving improvements in quality and slowing the growth in health care spending.
5	Eliminate health disparities in Suffolk County.	This goal is based on the belief that all people should have the opportunity

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#	Goal	Reason For Goal
		to reach their full potential for health. Yet, those at the lower ends of the socioeconomic spectrum (which disproportionately includes racial and ethnic minorities) often have lower access to care and fewer healthy lifestyle options. They often have higher rates of morbidity and mortality as compared to more socioeconomically advantaged populations. While movement toward this goal will require a multipronged strategy, PPS activities will include: Identifying and mapping high-need areas that experience health disparities and aligning existing resources to meet specific needs; developing and evaluating community-based interventions; supporting and expanding training programs that bring diverse workers (racial and ethnic balance) into the healthcare and public health workforce; and increasing the dissemination and use of evidence-based cultural competency and health literacy practices and interventions.
6	Transform the PPS into a highly efficient integrated delivery system.	The current healthcare delivery environment (structure and processes) that defines the context for the Suffolk PPS is too costly and often yields suboptimal patient outcomes. We aim to develop a system in which: patients' clinical information is available to providers at the point-of-care and to patients through electronic health record systems; patient care is coordinated across providers and transitions to different care settings are actively managed; providers are accountable to each other, review each other's work, and collaborate reliably to deliver care that is of high quality and value; patients have easy access to appropriate and culturally competent care and information, including after hours; there is clear accountability for the total care of patients; and the system is continuously innovating and learning how to improve quality, value, and the patients' experience.
7	Assure that all PPS operations integrate concepts of cultural competence and health literacy.	Cultural competency and health literacy are critical to reducing health disparities and improving access to high-quality health care--health care that is respectful of and responsive to the needs of diverse patients. This is essential if healthcare resources are to be used wisely to produce optimal patient outcomes.
8	Establish a solid foundation of team-based care across medical, behavioral, and social services.	This goal is fundamental to improving care coordination. As such, it will lead to the creation of processes and protocols for robust care coordination and transitional care. Care will be collaborative and coordinated for patients within medical homes and Health Homes. We will use cross-functional care teams that span the continuum of physical health, behavioral health, and social services, including long-term supports and services. Such teams will have well-defined roles and responsibilities and will work closely with primary care providers. We will transition to advanced primary care models consistent with the State Health Innovation Plan that support the integration of physical and behavioral health and that provide robust care coordination to engage patients in the self-management activities that will keep them from presenting to the ED and reduce unnecessary hospitalizations.
9	Assure that patients get the right care at the right time, while avoiding unnecessary services.	This goal reflects tenets of the Triple Aim which will make care safer and reduce costs. It includes a specific focus on reducing unnecessary admissions and ED visits. It is intended to encourage physicians and other providers to change their practice patterns (where needed) to reflect professional medical guidelines. Care will be evaluated using PPS-wide shared metrics. This will entail the design of standard operating procedures, a workforce with diverse yet complementary skills, workloads that allow enough time for errors to be corrected or mitigated, and leadership that promotes continuous improvement. This will lead to better, safer care by preventing serious medication errors, healthcare associated infections and other preventable events.

***Formulation:**

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

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We have designed a governance model that will assure that the PPS continues to meet the needs of the community. The organizational structure of the PPS is a variant of the Delegated Model described in the "Governance How to Guide" prepared by the DSRIP Support Team. A Board of Directors will serve as the principal mechanism for implementing an effective, shared governance structure for the PPS. The Board will have representatives from critical stakeholder groups, with nearly half of the members consisting of such individuals. The Board will also maintain a Community Needs Assessment and Outreach Committee, whose charge is to provide guidance in identifying community health needs and ensuring that the PPS's projects and other initiatives are effective in addressing such needs on an ongoing basis. The PPS will incorporate robust cultural competency and health literacy program as well as ongoing analysis of trends in health disparities and the needs of vulnerable populations.

***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.

We envision a permanently transformed system in which all Medicaid members will receive coordinated, patient-centered primary and specialty care; providers will be accountable for quality, patient experience, and cost; financial incentives will be aligned to reward providers for keeping patients healthy; and providers will effectively and sustainably partner with community organizations and consumers. MCOs, providers, and Health Homes will come together with CBOs to break down silos between acute care, behavioral health, and care for those with developmental disabilities. PPS members will work in common cause toward improved health outcomes. Medicaid FFS will be replaced by MCO-based payment and MCO benefit requirements will be largely (if not entirely) met by PPS members. CBOs will be integral partners in addressing the social determinants of health.

***Regulatory Relief:**

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

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

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

PPS' should be aware that the relevant NYS agencies may, at their discretion, determine to impose conditions upon the granting of waivers. If these conditions are not satisfied, the State may decline to approve the waiver or, if it has already approved the waiver, may withdraw its approval and require the applicant to maintain compliance with the regulations.

#	Regulatory Relief(RR)	RR Response
1	10 NYCRR 34-1.3; 10 NYCRR 34-2.3; 10 NYCRR 34-2.4 Currently Prohibited Business Practices	Regulations: • 10 NYCRR 34-1.3 prohibits practitioners from making referrals to a healthcare provider authorized to provide such services where such practitioner has a financial relationship with such health care provider. • 10 NYCRR 34-2.3 prohibits health services purveyors from accepting payment/consideration from a clinical laboratory (CL) for the referral for the performance of CL services. • 10 NYCRR 34-2.4 prohibits a CL from giving payment/consideration to a health services purveyor for the performance of CL services. Projects Implicated: 2ai, 2biv

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#	Regulatory Relief(RR)	RR Response
		Projects/Components: • 2ai. involves the creation of an integrated delivery system and requires that practitioners, health services purveyors, and CLs have the ability to provide integrated care using a team approach to address the overall health needs of a patient. • 2biv requires care managers/health professionals to create transition of care plans so patients may be transferred to the appropriate setting post-hospitalization. By transferring patients medically/geographically suitable facilities, providers can ensure that a patient's underlying/chronic conditions are addressed in a comprehensive manner and on a long-term basis. • 3ai requires providers to focus on cardiovascular health in adults, implementing Million Hearts Campaign strategies. PPS must be able to provide free screenings in the community to ensure that low or non-utilizing patients address their cardiovascular health; these patients may benefit from seeking follow up care within the PPS. Necessity of Waiver: The referenced regulations interfere with the projects by prohibiting the referral of patients to appropriate facilities. Such regulations will deter PPS providers from referring patients to settings for needed care, in fear of engaging in prohibited practices. DSRIP requires that the PPS include providers of all facets of healthcare to deliver care through an integrated network of providers who understand the importance of greater interconnectivity to address patient issues as a whole. By coordination/referral to appropriate healthcare settings, such providers are able to prevent fragmented care that fails to address the patient's overall health or may be duplicative. Alternatives: While the DOH Regulatory Flexibility Guidance indicates that the accountable care organization (ACO) certificate of authority may the appropriate means for obtaining relief from these regulations, the PPS currently is not ready to apply for ACO certification as it will be composed of 2 hubs. Patient Safety: Although these regulations are relevant to the issue of patient safety, waiver will not impact patient safety as the PPS's intends to provide integrated care addressing patient issues which may be overlooked or superseded by more emergent conditions. To contain possible risk to patient safety, the PPS will maintain clinical referral protocols for facilities/medical services that are medically necessary.
2	10 NYCRR 600.9(c) Revenue Sharing	Regulation: 10 NYCRR 600.9(c) regulates the sharing of the total gross income or net revenue of a medical facility by an individual, partnership or corporation which has not received establishment approval. Project Implicated: 2ai Projects Implicated: 2.a.i. involves the creation of an integrated delivery system and incentivizes providers to provide such care by tying funds flow to the success and meeting of project metrics by each partner in the PPS. Essentially, the success or failure of any one partner will impact the amount of funds distributed by the State to the entire PPS. Necessity of Waiver: The referenced regulation interferes with the proposed operation and stated goals of 2ai by prohibiting sharing of revenue which is contrary to the intent of DSRIP, which monetarily incentivizes the PPS and its partners to work as an integrated network and act as a team to deliver comprehensive care. Further, partners within the PPS would be unable to re-distribute DSRIP funds amongst other partners/providers as such disbursement might be considered an illegal kickback. Accordingly, a waiver of these regulations is required to permit successful Project

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#	Regulatory Relief(RR)	RR Response
		implementation and achievement of Project objectives. Without such a waiver, successful Project implementation will not be feasible. Alternatives: Although the PPS considered the accountable care organization (ACO) certificate of authority as an alternative to seeking a waiver, such an alternative would require restructuring of projects in a way contrary to the goals of the DSRIP program because the PPS will be composed of 2 hub entities, not currently ready to apply as ACOs. Patient Safety: It should be noted that 600.9(c) does not pertain to patient safety as it is intended to prevent illegal kickbacks. Hence, waiver of such regulation would not impact patient safety.
3	10 NYCRR 600.9(d); 10 NYCRR 405.3(f) Management Contracts	Regulations: • 10 NYCRR 600.9 states that a medical facility may not contract for management services with a party which has not received establishment approval. • 10 NYCRR 405.3(f) specifically prohibits contracting with an entity to assume the day-to-day operations of the entire facility or a unit of the facility. • 14 NYCRR 810.12 regulates the criteria and procedures for approval of management contracts. Projects Implicated: 2.a.i Project/Components: 2.a.i involves creation of an integrated delivery system focused on evidence-based medicine and population health management and requires that PPS providers have the flexibility to contract with other entities for the provision of management services for functions such as care coordination and information technology. Necessity of Waiver: The referenced regulations interfere with the proposed operation and stated goals of 2ai by interfering with the ability of the PPS to adequately create an integrated structure where particular vital operations are contracted to a third party to ensure that PPS providers are able to focus on provision of clinical care. Accordingly, a waiver of the regulations is required to permit successful Project implementation and achievement of Project objectives. Without such a waiver, successful Project implementation will not be feasible. Alternatives: The PPS has considered whether there is an alternative to seeking waiver but has concluded that any such alternative would require for each facility to take responsibility for every administrative and non-clinical function of its practice, which could threaten the sustainability of the Project. Patient Safety: It should be noted that 10 NYCRR 600.9(d), 10 NYCRR 405.3(f), and 14 NYCRR 810.12 do not pertain to patient safety as they are intended to provide a guidelines and an approval process for management service contracting and for appropriate entities to be able to share in proceeds of a particular medical facility. Hence, waiver of such regulations would not impact patient safety.
4	14 NYCRR 810.12(a) Management Contracts	Regulation: 14 NYCRR 810.12(a) regulates the criteria and procedures for approval of management contracts including submission of each contract to OASAS for approval and demonstrating need for the management contractor. Project Implicated: 3ai Projects/Components: 3ai involves the integration of primary care and

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#	Regulatory Relief(RR)	RR Response
		behavioral health services to provide comprehensive care and address the diverse needs of the attributed Medicaid population who may have underlying primary care or behavioral health issues which are not typically addressed at the first point of care. In order to provide such integration and allow providers to focus on providing quality care, 3ai requires that PPS providers have the flexibility to contract with other entities for the provision of management services of clinical services or the employment of managerial or clinical staff. Necessity of Waiver: The referenced regulation interferes with the proposed operation and stated goals of 3ai by interfering with the ability of the PPS providers to adequately create an integrated structure where particular vital operations are contracted to a third party to ensure that providers are able to focus on provision of clinical care. Accordingly, a waiver of the regulations is required to permit successful Project implementation and achievement of Project objectives. Without such a waiver, successful Project implementation will not be feasible. Alternatives: The PPS has considered whether there is an alternative to seeking waiver but has concluded that any such alternative would require restructuring of projects in a way contrary to the goals of the DSRIP program. Patient Safety: It should be noted that 14 NYCRR 810.12(a) does not pertain to patient safety as it is intended to provide a guidelines and an approval process for management service contracting for OASAS-related services. Hence, waiver of such regulations would not impact patient safety.
5	10 NYCRR 405.1(c) Active Parent	Regulation: 10 NYCRR 405.1(c) states that "any person…or other entity with the authority to operate a hospital must be approved for establishment by the [Public Health and Health Planning Council] unless otherwise permitted to operate by the Public Health Law." An operator is defined as an entity of a hospital who has decision-making authority over any of the active parent powers such as approval of hospital contracts for management or for clinical services, appointment or dismissal of hospital management-level employees and medical staff, approval of hospital operating and capital budgets, and adoption or approval of hospital operating policies and procedures. It also regulates the approval by the Public Health and Health Planning Council (PHHPC) of the operator of a hospital Project Implicated: 2.a.i Project/Components: 2.a.i involves creation of an integrated delivery system and requires that the lead entity and other PPS providers have the ability to establish internal structure and protocols for the purposes of uniform governance and DSRIP project implementation. Necessity of Waiver: The referenced regulation interferes with the proposed operation and stated goals of 2ai by interfering with the ability of the PPS to adequately create an integrated structure where structure and protocols are decided by a PPS governing body with the consultation of individuals, representative of the providers within the PPS. This regulation relegates such authority to entities that have been approved for establishment and restricts the PPS lead agency, Stony Brook University Hospital (SBUH), and other PPS providers from establishing an internal structure which may involve one or more of the functions listed above, for purposes of implementing other project plans. Accordingly, a waiver of the regulation is required to permit successful Project implementation and achievement of

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#	Regulatory Relief(RR)	RR Response
		Project objectives. Without such a waiver, successful Project implementation will not be feasible Alternatives: The PPS has considered whether there is an alternative to seeking waiver but has concluded that any such alternative would limit the PPS's decision-making authority and require restructuring of projects in a way contrary to the goals of the DSRIP program. Patient Safety: It should be noted that 10 NYCRR 405.1(c) does not pertain to patient safety as it is intended to instill active parent authority over which the PHHPC has oversight. Hence, waiver of such regulations would not impact patient safety.
6	10 NYCRR 400.9(a) Transfer and Affiliation Agreements	Regulation: 10 NYCRR 400.9(a) regulates the discharge or transfer of any patient or resident. The operator of the transferring/discharging facility must have in place a transfer and/or affiliation agreement with one or more facilities with valid operating certificates and one or more home health agencies certified by the DOH and serving a similar geographic area of coverage. Project Implicated: 2biv Project/Components: 2.b.iv requires care managers/health professionals to create transition of care plans so patients may be transferred to the appropriate setting post-hospitalization. By transferring patients to partner facilities that are medically/geographically suitable, providers can ensure that a patient's underlying and chronic conditions are addressed in a more comprehensive manner and on a long-term basis. Necessity of Waiver: The referenced regulation interferes with the proposed operation and stated goals of 2biv by requiring PPS provider to have in place transfer and/or affiliation agreements, approved by the DOH, which are duplicative to the agreements already in place with these provider/facilities through participation in the PPS. These PPS participation agreements ensure that partners will work together to achieve the goals of DSRIP and have in place compliance protocols to ensure adequate patient care and safety. Alternatives: The PPS has considered whether there is an alternative to seeking waiver but has concluded that any such alternative would burden each partner to execute duplicative agreements with other partners within the PPS. Patient Safety: It should be noted that although 10 NYCRR 400.9(a) is relevant to the issue of patient safety, waiver of such regulations will not impact patient safety as the PPS will have agreements in place with all partners, reinforcing the requirement to provide comprehensive care to the attributed Medicaid population in a compliant manner.
7	14 NYCRR 573.1 OMH- Operating Certificate Issuance and Limitation	Regulation: 14 NYCRR 573.1 regulates the issuance of an operating certificate (Certificate) by OMH to operate a mental health program such as a clinic and a comprehensive psychiatric emergency program (CPEP). Initial and subsequent Certificates may not be issued for a period to exceed three years. Project Implicated: 3ai Project/Components: 3ai involves the integration of primary care services and behavioral health. Successful Project implementation requires that the PPS have the ability to expand the provision of services in a primary care setting by providing "stepped care" through a community based primary

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#	Regulatory Relief(RR)	RR Response
		care physician (PCP) working in conjunction with mental health/behavioral and other health professionals. The Project may also require the establishment of CPEP in facilities that do not have an existing Certificate in order to address the shortage of such services in Suffolk County. Necessity of Waiver: The referenced regulation interferes with the proposed operation and stated goals of 3ai by requiring OMH licensed providers who are collaborating with primary care providers to obtain a satellite Certificate from OMH for the primary care setting. The period of time required for issuance of such Certificate is unclear, as the OMH will likely be inundated with similar applications from other PPSs. Nonetheless, the typical time period for issuance is approximately 3 to 4 months which will inhibit the PPS's ability to engage patients during the time the issuance is pending. Additionally, the Certificate is effective for a period not to exceed three years; as DSRIP is a 5 year program, the PPS will also have the administrative burden to apply for a subsequent renewal. Accordingly, a waiver of the regulation is required to permit successful Project implementation and achievement of Project objectives. Without such a waiver, successful Project implementation will not be feasible. Alternatives: The PPS has considered the alternative of requesting an expedited process of issuance from the OMH, however, such a process, does not exist at this time. Further, the PPS has considered participation as a Primary Care Host Model, as described in the Proposed DOH Rule regarding integration of outpatient services, however, this Proposed Rule is not yet effective as law. Moreover, this Rule requires that the individual provider participating in any model to obtain multiple certificates/licenses, defeating the purpose of avoiding administrative burden and delay. Patient Safety: It should be noted that although 14 NYCRR 573.1 is relevant to the issue of patient safety, waiver of such regulation will not impact patient safety because each PCP office within DSRIP is expected to meet Patient Centered Medical Home (PCMH) level 3 certification by Year 3; such high standards of accountability set forth by the federal government eliminate the need for further OMH oversight.
8	14 NYCRR § 599.3(d), 599.4(r) & (ab), 599.5(f); OMH- Certification for Clinical Treatment Programs	Regulation: The cited regulations regulate the certification of clinical treatment programs, specifically promulgating the requirements for satellite clinics. This includes licensed diagnostic and treatment centers (D&TCs) that provide more than 10,000 mental health visits annually, or for which mental health visits comprise over 30 percent of the annual visits. Requirements include obtaining a Certificate pursuant 14 NYCRR 551, compliance with OMH's proscribed methods of staff supervision, treatment planning, review of treatment plans, and record maintenance, and OMH notification for change in hours of operation. Projects Implicated: 2ai; 3ai Project/Components: 3ai involves the integration of primary care services and behavioral health. Successful Project implementation requires that OMH licensed providers collaborating with PCPs have the ability to provide mental health services at offsite locations. Additionally, the PPS has three OPWDD licensed partners that operate Article 28 facilities providing OPWDD-related mental health services, increasing the amount of annual mental health visits. PCPs will have the ability to provide a combination of services to patients who may have issues in visiting multiple facilities for various primary care-related and mental health issues. 2.a.i involves the creation of an integrated delivery structure that

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		incorporates the full continuum of services. The PPS will fill gaps in access to care by coordinating care in one location. 2.a.i involves the creation of an integrated delivery structure that incorporates the full continuum of services. The PPS will fill gaps in access to care by coordinating care in one location. Necessity of Waiver: The referenced regulations interfere with the proposed operation and stated goals of 2ai and 3ai by discouraging PCPs and other Article 28/31 facilities and mental health services to integrate. Specifically, the waiver is needed for the PPS to add services in existing provider locations without undue delay. Moreover, primary care sites, which could serve patients with mental health issues in an integrated manner, will be deterred from offering such services as to avoid the duplicative burden of complying with both DOH and OMH requirements. Deterrence of this kind will hinder the achievement of the goals of this Project as integrated primary and mental health care is necessary to improve the overall health outcomes of the Medicaid population. Alternatives: The PPS has considered whether there is an alternative to seeking waiver but has concluded that any such alternative would require primary care sites to comply with the requirements of the DOH, OMH, as well as the PCMH federal rules. Such a burden on PCPs threatens the sustainability of this Project. Patient Safety: Waiver of such regulation will not impact patient safety as it will make it easier for providers to treat patients in a holistic manner, which increases their health and safety. Moreover
9	14 NYCRR 599.9; 14 NYCRR 599.10; 14 NYCRR 599.11; 14 NYCRR 599.12(a) OMH- Staffing, Treatment etc.	Regulations: • 14 NYCRR 599.9 regulates staffing of clinical treatment programs including the appropriate number of staff, types and necessary qualifications, and OMH discretionary approval of qualified staff, as appropriate. • 14 NYCRR 599.10 regulates treatment planning that includes necessary documentation, time periods for completion, and periodic review. • 14 NYCRR 599.11 regulates case records including necessary documentation and confidentiality. • 14 NYCRR 599.12(a) regulates premises requirements including arrangement of spaces, program capacity, and appropriate furnishings. Project Implicated: 3ai Project/Components: 3ai involves the integration of primary care services and behavioral health. Successful Project implementation requires that PCPs have the ability to provide mental health services in their primary care sites. PCPs will have the ability to provide a combination of services to patients who may have issues in visiting multiple facilities for various primary care-related and mental health issues. Necessity of Waiver: The referenced regulations interfere with the proposed operation and stated goals of 3ai by requiring OMH licensed providers who collaborate with PCPs to comply with proscribed requirements. In addition to the duplicative nature of requiring OMH licensed providers collaborating with PCPs to comply with these requirements, such compliance may contribute to confusion among professionals and staff in such settings who will be mandated to comply with DOH and OMH. These regulations will discourage PCP and mental health partnerships which is counterproductive to the goals of this Project.

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		Alternatives: The PPS has considered whether there is an alternative to seeking waiver but has concluded that any such alternative would require primary care sites to comply with the requirements of the DOH, OMH, as well as the PCMH federal rules. Such a burden on PCPs threatens the sustainability of this Project. Patient Safety: Waiver of such regulations will not impact patient safety as it will make it easier for providers to treat patients in a holistic manner, which increases their health and safety. It should be noted that 14 NYCRR 599.12(a) does not pertain to patient safety and the waivers to design requirements are consistent with federal rules. PPS partners will provide care within the confines of the PCMH rules.
10	14 NYCRR 587.5 OMH- Operations of Outpatient Programs	Regulation: 14 NYCRR 587.5 regulates the operation of outpatient programs, specifically, the requirement to obtain a Certificate which is effective for a term up to three years. Outpatient programs are required to be separately identifiable, and comply with the requirements of the Certificate, as proscribed by 14 NYCRR 551, including hours of operation, program capacity, and population served. Projects Implicated: 3ai, 4aii Projects/Components: • 3ai involves the integration of primary care services and behavioral health and 4aii involves the prevention of substance abuse and other MEB disorders. Successful Project implementation requires that the PPS have the ability to provide mental and behavioral health through outpatient programs to treat adults with a diagnosis of mental illness or children with a diagnosis of emotional disturbance. Such programs allow for greater availability of treatment over a large and diverse geographic area such as Suffolk County. Necessity of Waiver: The referenced regulation interferes with the proposed operation and stated goals of 3ai and 4aii by requiring that the PPS submit application for a Certificate for each outpatient program it seeks to establish. Saddled with thousands of applications for outpatient programs, there will likely be a delay in approval as the State will have to process these applications and plan for inspections and re-certifications accordingly. Delay in approval will hinder the PPS's ability to implement the vital components of the Projects. Alternatives: The PPS has considered whether there is an alternative to seeking waiver but has concluded that any such alternative would require restructuring of projects in a way contrary to the goals of the DSRIP program. Pursuant to 14 NYCRR 587.3, this part does not apply to professional practices acting within the scope of their professional licensure. This, however, continues to implicate PCPs yet approved by OMH to provide mental and behavioral health services. Patient Safety: It should be noted that although 14 NYCRR 587.5 is relevant to the issue of patient safety, waiver of such regulation will not impact patient safety because the PPS does not seek to avoid compliance with the requirements of an OMH-approved outpatient program. The PPS desires the ability to eliminate or expedite administrative requirements that will delay the provision of integrated primary, mental and behavioral care.
11	14 NYCRR 85.4 Operation of Outpatient Facilities For the Mentally Disabled	Regulation: 14 NYCRR 85.4 regulates the operation of outpatient facilities for the mentally disabled by any clinic, center, institute, hospital, school, institution or other place operated by a corporation. This regulation requires that such a facility must obtain a Certificate that is effective for a period not to exceed two years.

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#	Regulatory Relief(RR)	RR Response
		Projects Implicated: 3ai, 4aii Projects/Components: 3ai involves the integration of primary care services and behavioral health and 4aii involves the prevention of substance abuse and other MEB disorders. Successful Project implementation requires that the PPS have the ability to provide mental and behavioral health in various settings such as skilled nursing facilities and schools. Increased accessibility to such services in alternative settings ensures that the PPS provides integrated care to a greater cross-section of attributed Medicaid patients to improve health outcomes. Necessity of Waiver: The referenced regulation interferes with the proposed operation and stated goals of 3ai and 4aii by requiring that the PPS submit Certificate applications for each outpatient facility it intends to operate for the mentally disabled. Saddled with thousands of applications for outpatient programs, there will likely be a delay in approval as the State will have to process these applications and plan for inspections and re-certifications accordingly. Delay in approval will hinder the PPS's ability to implement the vital components of the Project. Alternatives: The PPS has considered whether there is an alternative to seeking waiver but has concluded that any such alternative would limit the types and amount of facilities in which outpatient services may be provided. Such limitations would result in the attributed Medicaid population having less access to such services. Patient Safety: It should be noted that although 14 NYCRR 85.4 is relevant to the issue of patient safety, waiver of such regulation will not impact patient safety because the PPS does not seek circumvent compliance with the requirements for the operation of outpatient facilities but desires to prevent administrative burden which could delay implementation
12	14 NYCRR 620.7; 14 NYCRR 620.9; 14 NYCRR 620.10 Certification of Need For Administrative Review	Regulations: • 14 NYCRR 620.7 regulates the requirements for submitting an application for certification of need for a new program or construction. • 14 NYCRR 620.9 regulates the review of certification of need application for administrative review projects such as the expansion or contraction of specific services currently offered, an increase or decrease in certified capacity of an existing program, and the acquisition, construction, or capital expenditure for physical plant and/or equipment/assets in support of an existing program, or a combination thereof, estimated to be under $600,000 but more than $30,000. • 14 NYCRR 620.10 regulates the review of certification of need application for substantive review projects such as those expected to cost $600,000 or more and projects which exceed current certified capacity by 10 percent or 5 persons, whichever is greater. Projects Implicated: 3ai, 4aii Projects/Components: 3ai involves the integration of primary care services and behavioral health and 4aii involves the prevention of substance abuse and other MEB disorders. Successful Project implementation requires that the PPS have the ability to provide mental and behavioral health in various settings such Article 16 licensed facilities subject to OPWDD review. The overall health of many patients within the attributed population is impacted by a combination of primary care and mental/behavioral/OPWDD-related issues which may be better addressed in an integrated setting. Increased accessibility to such services in alternative settings ensures that the PPS provides integrated care to a greater cross-section of attributed Medicaid patients to improve health outcomes.

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		Necessity of Waiver: The referenced regulations interfere with the proposed operation and stated goals of the Projects by imposing the necessity of an administrative and/or substantial review by OPWDD for the provision of primary care, mental and behavioral health services in Article 16 licensed facilities. Such applications of review will likely be submitted by several other PPSs resulting in a delay in approval, and ultimately a delay in the provision of services. Alternatives: The PPS has considered whether there is an alternative to seeking waiver, such as an expedited process by the State, but has concluded that any such alternative does not currently exist. Given the short timeframe in between the submission and approval of the DSRIP Project Plan Application and the commencement of Year 1, a delay in approval to commence the implementation of the Projects may result in the failure of meeting Project metrics in the timeline proscribed by DSRIP. Patient Safety: It should be noted that although these regulations are relevant to the issue of patient safety, waiver of such regulations will not impact patient safety because the waiver is being sought to request an expedited process of review so that the PPS may commence provision of integrated care to meet the metrics for DY1.
13	14 NYCRR 810.8; 14 NYCRR 810.9 OASAS- Establishment, Incorporation, Certification Of Providers etc.	Regulations: • 14 NYCRR 810.8 regulates the full review process for projects proscribed under 14 NYCRR 810.5, including establishment of any service by a prospective provider that has not been previously certified by OASAS to provide substance use disorder services. Full review requires OASAS review for completeness, local government unit review, and review and recommendation from the Behavioral Health Services Advisory Council (Advisory Council). • 14 NYCRR 810.9 regulates the administrative review process for projects proscribed under 14 NYCRR 810.6, including establishment or operation of a new service by an existing provider of certified services, an increase in the capacity of a service, and the relocation of any certified service. Projects Implicated: 4aii Project/Components: 4.a.ii requires that the PPS have the ability to identify and implement evidence-based practices and environmental strategies to prevent underage drinking, substance abuse and other MEB disorders and to increase the understanding of evidence-based practices for smoking cessation among individuals with mental illness and/or substance abuse disorder. Such practices may include the provision of tobacco screenings by a mental health provider as a supplement to what is provided by an OASAS professional. Project implementation requires that the PPS facilitate collaboration between physical and behavioral health providers to reinforce an integrated delivery system and improve overall health outcomes. Such services may best be provided in off-site locations to increase accessibility in Suffolk County. Necessity of Waiver: The referenced regulations interfere with the proposed operation and stated goals of 4aii by imposing the necessity of a full and/or administrative review by OASAS for the provision of substance use disorder services by a mental provider and the addition of new services administered by OASAS providers. Several tiers of review will likely cause a delay in the provision of services. Additionally, the imposition of conditional certification and periodic inspections, pursuant to 14 NYCRR 810.13 and 810.14, may cause an interruption in the provision of services and adversely affect the quality of care.

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#	Regulatory Relief(RR)	RR Response
		Alternatives: The PPS has considered participation as a Substance Use Disorder Behavioral Care Host Model, as described in the Proposed DOH Rule regarding integration of outpatient services, however, this Proposed Rule is not yet effective as law. Further this Rule requires that the individual provider participating in any model to obtain multiple certificates/licenses, defeating the purpose of avoiding administrative burden and delay. Patient Safety: It should be noted that although these regulations are relevant to the issue of patient safety, waiver will not impact patient safety because waiver is being sought for mental health providers who would contribute to an enhanced tobacco dependence screening as a supplement to that provided by an OASAS p
14	14 NYCRR 822-4.9; 14 NYCRR 822-5.18 OASAS-Additional Locations for Chemical Dependent Outpatient	Regulations: • 14 NYCRR 822-4.9 regulates the provision of chemical dependence outpatient treatment services at additional locations which are dependent upon and subordinate to the main location of the provider. The provider of services must submit an application for additional locations which must be approved pursuant to 14 NYCRR 810 and comply with proscribed space and care protocols. • 14 NYCRR 822-5.18 regulates the provision of opioid treatment services at additional locations which are dependent upon and subordinate to the main location of the provider. The additional locations must have adequate space and may not exceed 100 additional patients. Projects Implicated: 4aii Project/Components: 4aii involves the prevention of substance abuse and other MEB disorders. Successful Project implementation requires that the PPS have the ability to provide drug treatment programs in various locations throughout Suffolk County. As chemical dependence and opioid use is correlated with behavioral health issues, accessible treatment is imperative to improving health outcomes and achieving the goals of this Project. Necessity of Waiver: The referenced regulations interfere with the proposed operation and stated goals of 4aii by restricting the establishment of additional locations for drug treatment programs to only those locations which are dependent upon and subordinate to the main location of the provider. Satellite OASAS locations, as proscribed in 14 NYCRR 810, have strict requirements that are difficult to meet and will create significant burden on PCP practices, threatening the sustainability of these Projects. Alternatives: The PPS has considered whether there is an alternative to seeking waiver but has concluded that any such alternative would prevent PCPs from providing drug treatment services and would, ultimately, discourage PCP and OASAS partnerships which is counterproductive to the goals of this Project. Patient Safety: It should be noted that although 14 NYCRR 822-4.9 and 14 NYCRR 822-5.18 are relevant to the issue of patient safety, waiver of such regulations will not impact patient safety because such integration will enable providers to focus on serving the diverse needs of patients to improve overall health outcomes.
15	10 NYCRR 401.1 DOH-Issuance of Operating Certificates	Regulation: 10 NYCRR 401.1 regulates the issuance of operating certificates for new facilities, including clinical treatment programs which provide medical services, other than health monitoring and health screening, that comprise more than five percent of total annual visits, as defined by 14 NYCRR 599.

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		Project Implicated: 3ai Project/Components: 3.a.i. involves the integration of primary care services and behavioral health. Successful Project implementation requires that behavioral health providers licensed by OMH have the ability to provide primary care services to address the overall health of patients, particular if such facility is the first point of service. Provision of such integrated services is imperative particularly when part of the attributed Medicaid population can be classified as low or non-utilizers of health services; the provision of primary care in a behavioral health setting may make primary care more accessible to the patient geographically and serve as an impetus to facilitate care management. Necessity of Waiver: The referenced regulation interferes with the proposed operation and stated goals of 3ai by imposing an administrative burden on behavioral health providers to satisfy the operational and economic elements necessary for issuance of a Certificate from the DOH. As behavioral health providers are already subject to similar requirements imposed by OMH, duplicative requirements imposes an unnecessary burden and threaten the sustainability of this Project. Alternatives: The PPS has considered participation as a Mental Health Behavioral Care Host Model, as described in the Proposed DOH Rule regarding integration of outpatient services, however, this Proposed Rule is not yet effective as law. Further this Rule requires that the individual provider participating in any model to obtain multiple certificates/licenses, defeating the purpose of avoiding administrative burden and delay. Patient Safety: It should be noted that although 10 NYCRR 401.1 is relevant to the issue of patient safety, waiver of such regulation will not impact patient safety because behavioral health providers are already required to comply with OMH requirements which address and protect patient health and safety.
16	10 NYCRR 83.5; 10 NYCRR 83.10 Registration of Shared Health Facilities and Shared Health Fac. etc.	Regulations: • 10 NYCRR 83.5 regulates the registration of shared health facilities which is effective for a period up to two years and includes specification of the kinds of medical care, services or supplied may be provided. • 10 NYCRR 83.10 regulates the establishment and maintenance of reports and internal utilization review audits which must be made available from time to time. Projects Implicated: 3ai, 4aii Projects/Components: 3ai involves the integration of primary care services and behavioral health and 4aii involves the prevention of substance abuse and other MEB disorders. Successful project implementation requires that the PPS have the ability to provide mental and behavioral health through outpatient programs to treat adults with a diagnosis of mental illness or substance use disorders or children with a diagnosis of emotional disturbance. Such programs allow for greater availability of treatment over a large and diverse geographic area such as Suffolk County. Necessity of Waiver: The referenced regulations interfere with the proposed operation and stated goals of 3ai and 4aii by imposing a burden on primary care and behavioral health providers to register as a shared facility every two years, at minimum; as DSRIP is a 5 year program, the PPS will have the administrative burden to apply for subsequent renewal. Further the DOH, may verify the application for registration by conducting an on sight visit and interviews, at its discretion. Moreover, the facility must maintain

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		and make available records in addition to any reports already generated. Such audit and investigation will hinder the provision of care by causing unnecessary delays and deter providers from participating in integrated care settings, threatening the sustainability of these Projects. Alternatives: The PPS has considered whether there is an alternative to seeking waiver but has concluded that any such alternative would require restructuring of projects in a way contrary to the goals of the DSRIP program. Patient Safety: It should be noted that 10 NYCRR 83.5 and 10 NYCRR 83.10 do not pertain to patient safety, as they are intended to prevent public confusion as to the connectivity of facilities for the purposes of obtaining necessary and appropriate care. Hence, waiver of such regulations would not impact patient safety.
17	10 NYCRR 83.19 General Structural Equipment and Safety Standards for Shared Health Facilities	Regulation: 10 NYCRR 83.19 regulates the general structural equipment and safety standards for shared health facilities including the required parameters for office space, public areas, clinical facilities, and diagnostic facilities. Projects Implicated: 3ai, 4aii Projects/Components: 3ai involves the integration of primary care services and behavioral health and 4aii involves the prevention of substance abuse and other MEB disorders. Successful Project implementation requires that the PPS have the ability to provide mental and behavioral health through outpatient programs to treat adults with a diagnosis of mental illness or substnace use disorders or children with a diagnosis of emotional disturbance. The PPS seeks to have OMH, OASAS, OPWDD licensed clinics integrate primary care services into their locations and, in some instances, there may be a need for two or more providers to share space (as permitted by DOH, OMH, and OASAS pursuant to an approved written plan consistent with federal rules). Necessity of Waiver: The referenced regulation interferes with the proposed operation and stated goals of 3ai and 4aii, imposing more stringent DOH space and facility requirements on mental and behavioral health providers. As a result of the comparably more stringent DOH requirements, the capital cost for mental and behavioral health providers will rise as they will be required to renovate their facilities to comply. Alternatives: The PPS has considered whether there is an alternative to seeking waiver but has concluded that any such alternative would require restructuring of projects in a way contrary to the goals of the DSRIP program as the potential rise in capital costs may deter mental and behavioral health providers from sharing space to provide patients with integrated care. Patient Safety: It should be noted that although 10 NYCRR 83.19 is relevant to the issue of patient safety, waiver of such regulation will not impact patient safety because, as mentioned above, the DOH, OMH and OASAS have determined that sharing of space is permitted upon execution of a written plan, consistent with federal rules which address protect patient safety.
18	14 NYCRR 814.7 OASAS-General Facility Requirements	Regulation: 14 NYCRR 814.7 regulates the general facility requirements for shared facilities, mandating providers sharing space to develop a written space use policy or plan in co-operation with such other entity. Projects Implicated: 3ai, 4aii

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		Projects/Components: 3ai involves the integration of primary care services and behavioral health and 4aii involves the prevention of substance abuse and other MEB disorders. Successful Project implementation requires that the PPS have the ability to provide mental and behavioral health through outpatient programs to treat adults with a diagnosis of mental illness or substance use disorders or children with a diagnosis of emotional disturbance. The PPS seeks to have OMH, OASAS, OPWDD licensed clinics integrate primary care services into their locations and, in some instances, there may be a need for two or more providers to share space (as permitted by DOH, OMH, and OASAS pursuant to an approved written plan consistent with federal rules). Necessity of Waiver: The referenced regulation interferes with the proposed operation and stated goals of 3ai and 4aii, imposing an additional requirement for development of a written plan which is duplicative of the written plan that may be submitted to the DOH, OMH, and OASAS, which is compliant with federal rules. Alternatives: The PPS has considered whether there is an alternative to seeking waiver but has concluded that requiring facilities to submit duplicative written plans will likely deter providers from integrating care, threatening the sustainability of the Projects. Patient Safety: It should be noted that although 14 NYCRR 814.7 is relevant to the issue of patient safety, waiver of such regulation will not impact patient safety because, as mentioned above, the DOH, OMH and OASAS have determined that sharing of space is permitted upon execution of a written plan, consistent with federal rules which address/protect patient safety.
19	10 NYCRR 401.2; 10 NYCRR 401.3 DOH-Limitations of Operating Certificates/Chgs in Existing Med. Fac.	Regulations: • 10 NYCRR 401.2 regulates limitations of Certificates including limiting usage of the Certificate by the established operator of the site. • 10 NYCRR 401.3 regulates changes in existing medical facilities including prohibiting the operator of a medical facility form leasing or subletting all or a portion of the facility, unless such facility and service performed complied with other medical facility provisions. Project Implicated: 3ai, 4aii Projects/Components: 3ai involves the integration of primary care services and behavioral health and 4aii involves the prevention of substance abuse and other MEB disorders. Successful Project implementation requires that the PPS have the ability to provide mental and behavioral health through outpatient programs to treat adults with a diagnosis of mental illness or substance use disorders or children with a diagnosis of emotional disturbance. The PPS seeks to have OMH, OASAS, OPWDD licensed clinics integrate primary care services into their locations and, in some instances, there may be a need for two or more providers to share space (as permitted by DOH, OMH, and OASAS pursuant to an approved written plan consistent with federal rules). Necessity of Waiver: The referenced regulations interfere with the proposed operation and stated goals of 3ai and 4aii by hindering the sharing of a facility by multiple providers as only the established operator of the facility may use the Certificate. Further, as may be necessary to incent various providers to deliver care in a shared setting, the operator is prohibited from leasing or subleasing space. Such regulations directly conflict with the proliferation of an integrated delivery system and deter achievement of the goals of DSRIP.

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		Alternatives: The PPS has considered whether there is an alternative to seeking waiver but has concluded that any such alternative would require clinics licensed by the DOH, OMH, and OASAS to duplicate space, segregate patients, have limited operating hours due to staffing issues, pay additional rent and have less than consistent and efficient work flow process. Patient Safety: It should be noted that although 10 NYCRR 401.2 and 10 NYCRR 401.3 are relevant to the issue of patient safety, waiver of such regulations will not impact patient safety because the PPS partners will ensure that patients seen at the proposed shared facilities will receive care appropriate to their needs and such care will occur with the confines of the PCMH rules.
20	10 NYCRR 709.1; 10 NYCRR 709.2 DOH-Determination of Public Need for Medical Facility Construction	Regulations: • 10 NYCRR 709.1 regulates the process of evaluation to determine public need pursuant to section 2802 of the Public Health Law. Several factors related to the needs and effects on the population in a specific geographic area are considered prior to approval for an application for public need. • 10 NYCRR 709.2 regulates the determination of public need for establishment of new/replacement beds in an acute care hospital and the need for acute care facilities/services which entails assessment of geographic needs and population, utilization rates, and types of beds needed. Projects Implicated: 2bix, 3ai Projects/Components: • 2bix requires establishment of appropriately sized observation units, particularly, in cases that are initiated in the emergency department which may require the need for observation services beyond the current physical capacity of a facility. Such units are better in placing observation patients in one area, rather than scattered throughout the facility, to address their needs in an efficient manner. Comprehensive/constant care in an observational unit will contribute to the overall reduction in avoidable hospital readmissions, one of the major goals of DSRIP. The PPS also plans to change the number of licensed extended observation beds in various partner facilities such as Southside Hospital to provide, much needed psychiatric services to patients who are unable to seek treatment at Stony Brook University Hospital (SBUH). Further, it is imperative to adjust the capacity of such beds at SBUH to address the mental health issues of the relevant patient population. • 3ai requires that the PPS have the ability to establish new outpatient programs/ offsite locations to extend the provision of mental health services to patients in need throughout Suffolk County. Necessity of Waiver: The referenced regulations impose the administrative burden of seeking approval for construction and addition of bed capacity pursuant to an evaluation of public need. Approval is at the discretion of an agency that will likely receive an influx of similar applications from other PPSs, delaying the process. The assessment for public need would also be duplicative as the PPS has already conducted a Community Needs Assessment, the results of which were utilized in selection of the Projects. Alternatives: The PPS has considered whether there is an alternative to seeking waiver but given the short timeframe in between the approval of the DSRIP Project Plan Application and the commencement of Year 1, a delay in approval to commence the implementation of the Projects may result in the failure of meeting Project metrics in the timeline proscribed by DSRIP.

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		Patient Safety: It should be noted that these regulations do not pertain to patient safety as the goals of the determination is to contain health care facility costs and allow coordinated planning of new services and construction throughout the State.
21	10 NYCRR 600.1(b)(1) & (b)(3), 600.2(b)(1) & (b)(3) DOH-Establishment of new medical facility	Regulation: This regulation sets forth the information to be contained within any application to the Public Health Council for the establishment of a new medical facility. Projects Implicated: 2ai Projects/Components: 2ai requires the creation of an integrated delivery structure that incorporates the full continuum of services for the PPS's patient population. In connection with this project, the PPS anticipates the potential construction of one or more new facilities in its service area. In addition to reducing costs, strengthening core clinical services and introducing new clinical initiatives, the construction of any such new facilities will measurably increase access to and quality of healthcare for the community being served by the PPS. Any such new medical facilities will have enhanced clinical and programmatic collaborations with other providers in the PPS, resulting in a more tightly aligned integrated delivery system. This project has the ability to substantially impact the health status of the population and better manage service utilization and the overall cost of healthcare. Thus, the PPS requests waiver of subsections 600.1(b)(1) and (b)(3), and 600.2(b)(1) and (b)(3) as similar reviews will be performed in connection with its DSRIP application. Necessity of the waiver: Denial of this waiver request would significantly delay the construction process, and affect the speed at which the PPS will be able to achieve the metrics associated with this project. Denial of the waiver would impede the closure of existing gaps in the care continuum, and result in the continuance of inefficient care with respect to areas where the existing medical facilities do not have the systems in place to triage ED patients or redirect them to urgent care, primary care, and/or behavioral health in lieu of ED usage. Patient safety: There are no patient safety risks associated with this waiver as similar reviews will be completed in connection with its DSRIP application. If DOH is not open to waiving this regulation the PPS would request the development of a more streamlined approval process so DSRIP project implementation is not delayed unnecessarily.
22	10 NYCRR 670.1 DOH-Factors for determining public need for new medical facility	Regulation: This regulation sets forth the factors for determining the public need for the establishment of a new medical facility. Projects Implicated: 2ai Projects/Components: 2ai requires the creation of an integrated delivery structure that incorporates the full continuum of services for the PPS's patient population. In connection with this project, the PPS anticipates the potential construction of one or more new facilities in its service area. In addition to reducing costs, strengthening core clinical services and introducing new clinical initiatives, the construction of such new facility will measurably increase access to and quality of healthcare for the community being served by the PPS. The PPS requests a waiver of the public need portion of the application process as a similar review will be performed in connection with the PPS's DSRIP project plan application, negating the need for a separate public need analysis. Furthermore, any such new medical facility will be better equipped to meet the medical needs of the PPSs Medicaid population and help to provide greater access to care, which will result in greater patient safety.

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		Necessity of the waiver: Denial of this waiver request would significantly delay the construction process, and affect the speed at which the PPS will be able to achieve the metrics associated with this project. Denial of the waiver would impede the closure of existing gaps in the care continuum, and result in the continuance of inefficient care with respect to areas where the existing medical facilities do not have the systems in place to triage ED patients or redirect them to urgent care, primary care, and/or behavioral health in lieu of ED usage. Patient safety: There are no patient safety risks to this waiver. Indeed, because the details surrounding the establishment of any new medical facility will be reviewed in connection with the project application, waiver of the public need analysis is simply eliminating a duplicative process.
23	10 NYCRR 710.2; 10 NYCRR 710.11 DOH-Approval of Medical Facility Construction	Regulation: • 10 NYCRR 710.2 regulates the approval process for an application to alter, improve, or modify a medical facility. This includes proposals requiring a certificate of need application such as addition of a licensed service and addition/replacement proposals involving a total project cost in excess of $6 million; proposals requiring full review and have a project cost in excess of $15 million; and proposals eligible for administrative review such as the addition/modification/change in the method of delivery of a licensed service, modification of information systems, and the addition of primary care sites. • 10 NYCRR 710.11 regulates the schedule for construction applications for the review of project scope and concept construction applications by the health systems agencies, the DOH, and PHHPC. Projects Implicated: 2ai, 2bix, 3ai, 4aii Projects/Components: • 2ai involves the creation of an integrated delivery system and requires that the PPS have the ability to provide integrated care through utilization of information system platforms to ensure connectivity and communication amongst the PPS. • 2bix involves the implementation of observational programs in hospitals. This Project will require construction of observational units in close proximity to particular areas of a hospital to facilitate providers in administering care in an area exclusive to observational patients to expeditiously meet patient needs. • 3ai requires that the PPS have the ability to expand the provision of primary care in alternative settings so that PCPs may work in conjunction with mental health/behavioral health professionals. This Project will require the addition/modification of licensed services provided in off site locations/addition of primary care sites. Necessity of Waiver: The referenced regulations interfere with the proposed operation and stated goals of 2ai, 2bix, and 3ai by requiring the PPS to submit applications for each Project component that requires DOH approval for construction/modification and subscribe to the established application review schedules. The State will receive similar applications from other PPSs, resulting in a delay in approval and ultimately, the failure in achieving Project metrics in Year 1. Alternatives: The PPS has considered whether there is an alternative to seeking waiver, such as an expedited process by the State, but has concluded that any such alternative does not currently exist. Given the short timeframe between the submission/approval of the DSRIP Project Plan application and commencement of Year 1, submission of several separate applications will impose a significant burden on the PPS as well as

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		DOH, who must approve each submission. Patient Safety: It should be noted that 10 NYCRR 710.2 and 10 NYCRR 710.11 do not pertain to patient safety as the intent for requiring DOH approval is to contain health care facility costs and allow coordinated planning of new services and construction throughout NYS.
24	10 NYCRR 712-2.4; 10 NYCRR 715.2.4 Standards of Construction For General Hospital Facilities	Regulation: • 10 NYCRR 712-2.4 regulates general hospital construction projects approved or completed after January 1, 2011 that includes approval by the DOH for modifications or deletions in space requirements when services are permitted to be shared. • 10 NYCRR 715-2.4 regulates standards of construction for freestanding ambulatory care facilities after December 31, 2010 that includes DOH approval for appropriate deletions and modifications in space and equipment requirements may be made to avoid duplication, when services are shared or purchased. Projects Implicated: 2bix, 3ai, 4aii Projects/Components: • 2bix involves the implementation of observational programs in hospitals. The Project involves establishment of appropriately sized observation units in close proximity to particular areas of a hospital. This Project will require construction of observational units to facilitate providers to administer care in a setting exclusive to observational patients and conversion of beds to address the needs of the attributed Medicaid population. • 3ai involves the integration of primary care services and behavioral health and 4aii involves the prevention of substance abuse and other MEB disorders. Successful Project implementation requires that the PPS have the ability to provide mental and behavioral health through outpatient programs to treat adults with a diagnosis of mental illness or substance use disorders or children with a diagnosis of emotional disturbance in off site locations. Such programs allow for greater availability of treatment over a large and diverse geographic area such as Suffolk County. Necessity of Waiver: The referenced regulations interfere with the proposed operation and stated goals of 2bix, 3ai and 4aii by requiring the PPS submit separate applications in order to seek waiver from the construction and design requirements imposed by the DOH. Given the short timeframe between the submission and approval of the DSRIP Project Plan application and commencement of Year 1, preparation of submission of several separate applications will impose a significant burden on the PPS as well as the DOH, who must approve each submission. Alternatives Considered: The PPS has considered whether there is an alternative to seeking waiver, such as an expedited process by the State, but has concluded that any such alternative does not currently exist. Patient Safety: It should be noted that 10 NYCRR 712-2.4 and 10 NYCRR 715.2.4 do not pertain to patient safety and the waivers are consistent with federal rules.
25	14 NYCRR 814.2; 14 NYCRR 814.3; 14 NYCRR 814.6; 14 NYCRR 814.8 OASAS- General Facility Requirements	Regulations: • 14 NYCRR 814.2 regulates the building code requirements for facilities providing OASAS facilities. • 14 NYCRR 814.3 regulates requirements for all facilities such as floor plan and general building parameters. • 14 NYCRR 814.6 regulates additional requirements for all outpatient facilities including a waiting area, appropriate to the type of certified service

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		and space for provision of services. • 14 NYCRR 814.8 regulates space alterations to physical space utilized for chemical dependence services, including requests for additional space, changes in space designations and/or other alterations, which requires prior written approval from OASAS. Projects Implicated: 3ai, 4aii Projects/Components: 3ai involves the integration of primary care services and behavioral health and 4aii involves the prevention of substance abuse and other MEB disorders. Successful Project implementation requires that the PPS have the ability to provide mental and behavioral health through outpatient programs to treat adults with a diagnosis of mental illness or substance use disorders or children with a diagnosis of emotional disturbance in off site locations. Additionally, these Projects require the modification of existing facilities to accommodate for the increased scope of services provided to facilitate integration. Such programs allow for greater availability of treatment over a large and diverse geographic area such as Suffolk County. Necessity of Waiver: The referenced regulations interfere with the proposed operation and stated goals of 3ai and 4aii by requiring the PPS submit separate applications in order to seek waiver from the construction and design requirements imposed by the OASAS. Given the short timeframe between the submission and approval of the DSRIP Project Plan application and commencement of Year 1, preparation of submission of several separate applications will impose a significant burden on the PPS as well as OASAS, who must approve each submission. Alternatives Considered: The PPS has considered whether there is an alternative to seeking waiver, such as an expedited process by the State, but has concluded that any such alternative does not currently exist. Patient Safety: It should be noted that 14 NYCRR 814.2, 14 NYCRR 814.3, 14 NYCRR 814.6, and 14 NYCRR 814.8 do not pertain to patient safety and the waivers are consistent with federal rules.
26	14 NYCRR 77.2; 14 NYCRR 77.7; 14 NYCRR 77.10 Standards for Physical Facilities of Hospitals etc.	Regulations: • 14 NYCRR 77.2 regulates the site and space utilization plan that must be prepared and maintained by each hospital for the mentally ill, school for the mentally retarded and alcoholism facility. • 14 NYCRR 77.7 regulates design and space requirements for all facilities including parameters for living unit and office spaces. • 14 NYCRR 77.10 regulates design and space requirements for alcoholism facilities including parameters for interview, examination, and treatments rooms. Projects Implicated: 3ai, 4aii Projects/Components: 3ai involves the integration of primary care services and behavioral health and 4aii involves the prevention of substance abuse and other MEB disorders. Successful Project implementation requires that the PPS have the ability to provide mental and behavioral health in shared settings to treat adults with a diagnosis of mental illness or substance use disorders or children with a diagnosis of emotional disturbance. Additionally, these Projects require the modification of existing facilities to accommodate for the increased scope of services provide to facilitate integration. Such programs allow for greater availability of treatment over a large and diverse geographic area such as Suffolk County.

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#	Regulatory Relief(RR)	RR Response
		Necessity of Waiver: The referenced regulations interfere with the proposed operation and stated goals of 3ai and 4aii by requiring the PPS submit separate applications in order to seek waiver from the construction and design requirements imposed by the OASAS. Given the short timeframe between the submission and approval of the DSRIP Project Plan application and commencement of Year 1, preparation of submission of several separate applications will impose a significant burden on the PPS as well as OASAS, who must approve each submission. Alternatives Considered: The PPS has considered whether there is an alternative to seeking waiver, such as an expedited process by the State, but has concluded that any such alternative does not currently exist. Patient Safety: It should be noted that although 14 NYCRR 77.2, 14 NYCRR 77.7, and 14 NYCRR 77.10 are relevant to the issue of patient safety, waiver of such regulations will not impact patient safety because the PPS partners will ensure that patients seen at the proposed shared facilities will receive care appropriate to their needs and such care will occur with the confines of the PCMH rules.
27	10 NYCRR 710.9 DOH-Approval of Medical Facility Construction	Regulation: 10 NYCRR 710.9 regulates onsite inspection or pre-opening survey of projects requiring DOH approval before an operating certificate may be issued or occupation of the facility. Projects Implicated: 2bix, 3ai, 4aii Projects/Components: • 2bix involves the implementation of observational programs in hospitals. The Project involves establishment of appropriately sized observation units in close proximity to particular areas of a hospital. This Project will require construction of observational units to facilitate providers in administerimg care in a setting exclusive to observational patients and conversion of beds to address the needs of the attributed Medicaid population. • 3ai involves the integration of primary care services and behavioral health and 4aii involves the prevention of substance abuse and other MEB disorders. Successful Project implementation requires that the PPS have the ability to provide mental and behavioral health through outpatient programs to treat adults with a diagnosis of mental illness or substance use disorders or children with a diagnosis of emotional disturbance in off site locations. Such programs allow for greater availability of treatment over a large and diverse geographic area such as Suffolk County. Necessity of Waiver: The referenced regulation interferes with the proposed operation and stated goals of 2bix, 3ai and 4aii by requiring that a pre-opening survey be conducted before a facility may be occupied, and if applicable, prior to issuance of an operating certificate. Given the short timeframe between the submission and approval of the DSRIP Project Plan application and commencement of Year 1, there will likely be a flux in inspections for facilities as a result of DSRIP causing delays, which ultimately will interfere with the PPSs ability to meet Project metrics for Year 1. Alternatives Considered: The PPS has considered whether there is an alternative to seeking waiver, such as an expedited process by the State, but has concluded that any such alternative does not currently exist. Patient Safety: It should be noted that although 10 NYCRR 710.9 is relevant to the issue of patient safety, waiver of such regulations will not impact patient safety because the PPS does not intend to circumvent oversight by the DOH but is seeking an expeditious process by which to

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		obtain approval to commence Project implementation.
28	Policy that prohibits Medicaid beneficiaries from participating in HH and MLTC plans simultaneously	Regulation: Under this policy, Medicaid patients cannot be members of both a Health Home and a Managed Long Term Care Plan. Projects Implicated: 2ai Projects/Components: The PPS's service area has a high rate of patients with poor mental health, and much of the ED and hospital utilization for the Medicaid population is by patients with psychiatric diagnoses. The fact that Medicaid patients cannot simultaneously be members of Health Homes and MLTCs creates a barrier to the provision of more integrated care that focuses on the needs of patients. Health Home care management is behavioral health focused, while MLTC care is more concentrated on patients' physical health. MLTCs in the PPSs service area are lacking in behavioral health expertise. Currently, for Medicaid patients with mental health conditions that are not adequately managed and monitored through MLTCs, the only alternative is for patients to go see an independent mental health provider, or present to hospitals for treatment. These are poor alternatives. Requiring patients to see multiple providers creates a barrier to accessing care, and increases the likelihood that patients will not seek the care that they need. This is especially true in rural areas. Health home care managers can make home visits and have the experience necessary to coordinate care related to mental health conditions. The goal of project 2ai is to create an integrated delivery structure that incorporates the full continuum of services for the PPS's patient population. The PPS may expand the integrated care models currently being utilized by its participating Health Homes in order to transform the current care delivery system. An expansion of Health Home services to patients that are members of MLTCs will bring mental health care coordination services to a greater portion of the PPS's Medicaid population, and will fill a gap in MLTC care. This will also reduce the amount of unnecessary hospital visits. Necessity of the waiver: Thus, waiver of this policy is necessary to provide more integrated care to the Medicaid population and will assist the PPS in meeting its goal of shifting care from hospitals to community providers. Patient safety: There are no patient safety risks to this waiver. Indeed, allowing Medicaid patients to be members of both Health Homes and MLTCs will increase patient safety by bringing needed mental health care and management services to MLTC patients who may currently be lacking this care.
29	Policy that denies care in Transitional Care Units to Medicaid beneficiaries	Regulation: Section 2802-a of the PHL defines transitional care units as sub-acute care services provided to patients of a general hospital who no longer require acute care general hospital inpatient services, but continue to need specialized medical, nursing and other hospital ancillary services and are not yet appropriate for discharge. Stays are limited in duration and designed to resolve a patient's sub acute care medical problems and result in the timely and appropriate discharge of such a patient to a home, residential health care facility or other appropriate setting. Projects Implicated: 2ai; 2biv Projects/Components: The PPS requests that TCU services be made available to its Medicaid population – 2.a.i: One goal of this project is to create an integrated, collaborative and accountable service delivery structure that eliminates fragmentation and concentrates on delivering high quality care in the right setting. The PPS believes that there is an absence of sufficient post-discharge services for

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		patients who require continued care post-discharge in a nursing home or other appropriate setting. Allowing Medicaid patients to access care in TCUs will ensure that they are receiving the care they need and ultimately result in reduced lengths of stay. 2.b.iv: The goal of this project is to reduce 30-day readmissions. Receipt by Medicaid patients of care in TCUs will ensure that they are not discharged from hospitals in situation where they could benefit from the specialized medical, nursing and other ancillary services hospitals can provide. This in turn will reduce readmissions, and result in more collaborative relationships between hospitals and long term care providers in the community, which will help bring about more efficient allocation of patients between the two settings. Necessity of the waiver: Thus, waiver of this policy is necessary to provide transitional care services to the Medicaid population. Patient safety: There are no patient safety concerns associated with this request. On the contrary, patient safety will be increased if such services were made available to Medicaid patients.
30	10 NYCRR 405.9(f)(7) General Hospital Discharges	Regulation: 10 NYCRR 405.9(f)(7) regulates hospitals to ensure that no person presented for medical care shall be removed, transferred or discharged from a hospital based upon source of payment. Project Implicated: 2biv Project/Components: Project 2.b.iv involves implementation of a care transition intervention model to reduce 30-day readmission for chronic health conditions. Successful Project implementation requires care managers and other health professionals to create transition of care plans and protocols so patients may be transferred to the appropriate setting post-hospitalization. By transferring patients to facilities that are medically and geographically suitable, providers can ensure that a patient's underlying and chronic conditions are addressed in a more comprehensive manner and on a long-term basis. Necessity of Waiver: The referenced regulation interferes with the proposed operation and stated goals of 2biv as "source of payment" may be interpreted as applying to DSRIP funding and could prevent a hospital from transferring a patient to the appropriate location. Accordingly, a waiver of the regulation is required to permit successful Project implementation and achievement of Project objectives. Without such a waiver, successful Project implementation will not be feasible. Alternatives: The PPS has considered whether there is an alternative to seeking waiver but has concluded that any such alternative would require restructuring of projects in a way contrary to the goals of the DSRIP program. Patient Safety: It should be noted that 10 NYCRR 405.9 does not pertain to patient safety as it is intended to prevent patient discrimination based on source of payment. Hence, waiver of such regulation would not impact patient safety. To contain any possible risk to patient safety, the PPS will establish evidence-based protocols for the transferring of patients to facilities that ensure the best health outcomes for patients.
31	18 NYCRR § 505.10 Prior authorization for non-emergency transportation services	Regulation: This regulation requires that prior authorization for non-emergency transportation services be granted prior to transportation expenses being incurred.

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		Project Implicated: 2ai; 2biv Project/Components: Transportation is a significant problem in the PPS's service area. As a result, any actions that can be taken to facilitate more rapid transfers to care facilities would result in more efficient care for the PPS's Medicaid population. Thus, the PPS requests that: 1) its participating providers be enabled to request non-emergency transportation directly from individual transportation vendors, and 2) individual transportation vendors be authorized to generate prior authorizations. The PPS believes that there will be greater utilization of community based providers if these waivers are granted. 2.a.i: One goal of this project is to create an integrated, collaborative and accountable service delivery structure that eliminates fragmentation and concentrates on delivering high quality care in the right setting. Waiver of the regulation would make utilization of nonemergency transportation services easier for Medicaid beneficiaries and will lead to a more integrated and accessible care delivery system. 2.b.iv: The goal of this project is to reduce 30-day readmissions. The patient population that is the target of this project includes patients that have diagnoses such as cardiac, renal and behavioral health disorders who are at a high risk of readmission. These patients will continue to need care post-discharge, and ED transition teams will be concentrating on referring patients to appropriate community providers with capacity to see patients in a timely manner. Waiver of the regulation will make utilization of nonemergency transportation services easier for Medicaid beneficiaries, resulting in fewer 30-day readmissions. Necessity of Waiver: Waiver of the regulation would make utilization of nonemergency transportation services easier for Medicaid beneficiaries and will lead to a more integrated and accessible care delivery system under 2ai and to fewer 30-day readmissions under 2biv. Patient Safety: There are no patient safety concerns associated with this waiver request as it will lead to increased access to care, and an order from a patient's medical practitioner would still be required.
32	10 NYCRR 405.19(g) Emergency Services	Regulation: 10 NYCRR 405.19(g) regulates hospital observation units for the provision of emergency services including physical space and staffing requirements. Such units may be used only for observation, diagnosis and stabilization of those patients for whom diagnosis and a determination concerning admission, discharge, or transfer cannot be accomplished within eight hours, but can reasonably be expected within 24 hours. Project Implicated: 2bix Project/Components: 2bix involves the implementation of observational programs in hospitals. Successful Project implementation requires that the PPS have the ability to establish appropriately sized and staffed observation units in close proximity to emergency department services. Patients will benefit from observational care in such units that can be provided beyond the proscribed 24-hour period, without admission. Necessity of Waiver: The referenced regulation interferes with the proposed operation and stated goals of the 2bix by limiting the amount of time a patient may be in observation and the number of observation beds to 5 percent of a hospital's certified bed capacity, requiring distinct space and approval for construction of such units. Accordingly, a waiver of the regulation is required to permit successful Project implementation and

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		achievement of Project objectives. Without such a waiver, successful Project implementation will not be feasible. Alternatives: The PPS has considered whether there is an alternative to seeking waiver but has concluded that any such alternative would require restructuring of the Project in a way contrary to the goals of the DSRIP program, specifically the reduction of avoidable hospital readmissions. Patient Safety: It should be noted that 10 NYCRR 405.19(g) does not pertain to patient safety as it is intended to provide guidelines to hospitals to facilitate the efficient and appropriate use of space. Hence, waiver of such regulation would not impact patient safety.
33	14 NYCRR 580.4 Operation Of Psychiatric Inpatient Units Of General Hospitals	Regulation: 14 NYCRR 580.4 regulates the issuance of an operating certificate for a general hospital which intends to operate a psychiatric inpatient unit, which is valid for a period not to exceed three years. Project Implicated: 2bix Project/Components: 2bix involves the implementation of observational programs in hospitals. Successful Project implementation requires that the PPS have the ability to establish appropriately sized and staffed observation units in close proximity to emergency department service, specifically to care for patients who need emergency psychiatric observation. Presently, there are hospitals in the Suffolk County area, without an existing CPEP, that could provide emergency psychiatric observational services to patients in need, for the 48 hour period as proscribed by MHL 9.39, who are either unable to travel to Stony Brook University Hospital (SBUH) or are admitted to SBUH due to the lack of capacity for CPEP cases. Necessity of Waiver: The referenced regulation interferes with the proposed operation and stated goals of 2bix by requiring the application for an operating certificate by OMH to provide inpatient psychiatric services. OMH will likely receive a large amount of applications from PPSs throughout the State, resulting in a delay in issuance and ultimately, delay the achievement of Project metrics in Year 1. Given the limited availability of CPEP available in the Suffolk County area, provision of psychiatric observational services by hospitals other than SBUH within the PPS are necessary to address the needs of the attributed Medicaid population. Alternatives: The PPS has considered whether there is an alternative to seeking waiver but has concluded that any such alternative would undermine the goals of DSRIP as the current shortage in psychiatric observational services will result in hospital admissions and likely, avoidable readmissions. The OMH does not have an expedited process in place to facilitate the implementation of DSRIP projects. Patient Safety: It should be noted that although 14 NYCRR 580.4 is relevant to the issue of patient safety, waiver of such regulation will not impact patient safety because the PPS will ensure that extended observational beds for the purposes of psychiatric care provide patients a safe environment where staff can provide continued monitoring and care.
34	14 NYCRR 590.5 Operation of Comprehensive Psychiatric Emergency Program (CPEP)	Regulation: 14 NYCRR 590.5 regulates the issuance of an operating certificate for a general hospital that intends to operate a CPEP. General hospitals must demonstrate public need, a willingness to serve ethic minorities, poor and medically indigent patients, and comply with physical plant requirements. Project Implicated: 2bix

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		Project Components: 2bix involves the implementation of observational programs in hospitals. Successful Project implementation requires that the PPS have the ability to establish appropriately sized and staffed observation units in close proximity to emergency department services. The addition of CPEP units in hospitals will ensure that the attributed Medicaid population has greater access to emergency psychiatric care, as currently, the six extended observational beds dedicated to CPEP at SBUH are not sufficient to address the needs of the PPSs population as a whole. Availability of increased CPEP services will ensure that mental/behavioral health issues are addressed and monitored within a unit designated for this type for care. Necessity of Waiver: The availability of extended observation beds assist in easing inappropriate and often short-term inpatient admissions. The most recent statewide review of CPEP programs found that only 27 percent of the patients admitted to extended observation beds were hospitalized after their stays. Many patients in the Suffolk County area are in need of short term stays, less than the 72-hour period proscribed by MHL 9.40, for psychiatric care and do not need to be admitted as an inpatient, however, CPEP capacity across the county is lacking. OMH will likely receiving similar applications for operating certificates to establish CPEP units from other PPSs, resulting in a delay in issuance and ultimately, the PPS's failure to meet Project metrics by Year 1. Alternatives: The PPS has considered whether there is an alternative to seeking waiver but has concluded that any such alternative would undermine the goals of DSRIP as the current shortage in psychiatric observational services will result in short-term hospital admissions and likely, avoidable readmissions. The OMH does not have an expedited process in place to facilitate the implementation of DSRIP projects. Patient Safety: It should be noted that although 14 NYCRR 590.5 is relevant to the issue of patient safety, waiver of such regulation will not impact patient safety because the PPS will ensure that extended observational beds for the purposes of CPEP provide patients a safe environment where staff can provide continued monitoring and care.
35	14 NYCRR 599.17(b) Telepsychiatry Services	Regulation: • 14 NYCRR 599.17(b) states that telepsychiatry services must be administered "where both the recipient and the physician or nurse practitioner are physically located at [OMH licensed] clinic sites." Provision of such services must be approved by the OMH, which requires the submission of a written plan to the Field Office, who may make an onsite visit prior to issuing approval. Project Implicated: 3ai, 4.a.ii Project/Components: 3ai and 4aii require that the PPS have the ability to expand the provision of mental health services in settings which are more accessible to the attributed patient population. Low-mobility and transportation issues result in many patients not receiving mental health services which may ultimately result in poor health outcomes and hospital admissions and readmissions. These Projects will require that telepsychiatry services be provided to the patient in their home or settings other than licensed OMH clinics. Necessity of Waiver: The referenced regulation interferes with the proposed operation and stated goals of 3ai adn 4.a.ii by limiting a provider's ability to provide telepsychiatry services to patients located at sites other than those licensed as clinics by OMH, such as their homes. Further, this regulation

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		imposes the burden to submit a written plan and seek approval by a Field Office prior to the rendering of care. Field Offices will likely be inundated with plans and request for approval from other PPS's, and subsequent need for inspection, which may result in a delay in issuing such approval. Delay in approval will hinder the PPS's ability to implement vital components of the Projects and result in poor health outcomes of the attributed Medicaid population. Alternatives: The PPS has considered whether there is an alternative to seeking waiver but has concluded that any such alternative would undermine the goals of DSRIP as the PPS would be unable to address the mental health needs of patients of low-mobility or who lack resources to obtain transportation to licensed clinics. Such discrepancy in care may likely lead to avoidable hospital admissions and readmissions. Patient Safety: It should be noted that although 14 NYCRR 599.17(b) is relevant to the issue of patient safety, waiver of such regulation will not impact patient safety because PPS providers will implement that same standards and protocols for provision of psychiatry services to both patients receiving such services in a licensed clinic or in their home.
36	10 NYCRR 415.3(d)(1); 10 NYCRR 751.9(n); 10 NYCRR 763.2(a)(10); 10 NYCRR 766.1(a)(11); 794.1(a) (10	Regulations: • 10 NYCRR 415.3(d)(1) states a nursing home resident's right to approve/refuse the release of health records to any individual outside the facility. • 10 NYCRR 751.9(n) states a D&TC patient's right approve or refuse the release/disclosure of the contents of medical records to any practitioner and/or facility. • 10 NYCRR 763.2(a)(10) states a CHHA, LTC, or Home Care patient's right to refuse release of records to any individual outside the agency. • 10 NYCRR 766.1(a)(11) states licensed home care agency patient's right to refuse release of records to any individual outside the agency. • 10 NYCRR 794.1(a)(10) states a hospice patient's right to refuse release of records to any individual outside the facility. Project Implicated: 2a.i Project/Components: 2ai requires that the PPS have the ability to share patient health information (PHI) from different types of facilities and providers for purposes of diagnosis, treatment and care management. 2ai require the utilization of health information exchanges (HIE) and other information technology platforms to disseminate PHI in real time to coordinate a patient's transitions from setting to setting. Necessity of Waiver: The referenced regulations interfere with the proposed operation and stated goals of the 2ai by serving as an impediment to the process of PHI sharing by imposing administrative hurdles that are unnecessary to maintain the confidentiality of such information. This burden is then transferred to the patient who must opt-in to a function (i.e., information sharing) that is crucial to their long-term care. In order to proactively manage overall health outcomes, it is imperative for PHI to be housed on a secure platform from which providers may analyze and evaluate such PHI to determine the best care and delivery methodologies for each patient individually. The necessity to obtain consent from the patient to authorize PHI sharing with new providers from time to time is unnecessarily duplicative and will likely lead to inefficiencies in care. Alternatives: Requiring that a patient execute a universal opt-in consent form is an arduous task that will slow down the provision of care as patients must decide with whom PHI may be shared which may be overwhelming,

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		particularly at the first point of care. Further, such a list of authorized providers is subject to change as alternative providers and facilities are found uniquely suitable to the patient's needs. Patient Safety: It should be noted that these regulations do not pertain to patient safety as they are intended to address confidentiality and give patients the right to authorize the release of PHI. These functions would not be altered by the utilization of an alternative consent such as the patient opt-out method because patients will still make an informed decision regarding the usage of PHI and would be given a reasonable time period before PHI IS included on an integrated platform.

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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 PPS's coalition includes over 240 coalition partners across the continuum of care, including FQHCs, medical groups, behavioral health providers, hospitals, SNFs, CHHAs, development disability providers, and community-based organizations. The coalition serves as the foundation for the development of an integrated delivery system promoting the coordination of physical health, behavioral health, and social services, with the goal of improving the health status and reducing total healthcare costs for Suffolk County's Medicaid and uninsured populations.

The PPS will begin operations under the Delegated Model, as shown on the organizational chart attached as Appendix A. Stony Brook University Hospital (SBUH) serves as the lead provider. To develop a shared governance structure, SBUH will delegate key responsibilities for the governance and administration of the coalition to a separate entity, SB Clinical Network IPA, LLC ("IPA"). While the IPA is a subsidiary of SBUH, it will be governed by its own, separate Board of Directors ("BOD") that will include representatives from the stakeholder groups included within the coalition partners, as described below. The BOD will serve as the governance committee for the

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PPS, providing oversight and strategic direction for the PPS and holding the PPS's management accountable for meeting the PPS's goals. The BOD will be granted decision-making authority with respect to: (a) financial governance, including distribution of DSRIP funds, budget development, and monitoring of financial impact across the partners; (b) clinical governance; (c) IT/ data governance; (d) compliance; and (e) other administrative functions. SBUH, as the lead provider of the PPS and the parent of the IPA, has reserved powers customarily granted to a sole member of a limited liability company, such as the right to approve BOD decisions relating to the sale of the company or the incurrence of debt.

In addition, the BOD will maintain the following advisory committees:
(a) 2 committees created to maximize the voice of the PPS's stakeholders in its governance: (i) the PAC, formed in accordance with DOH's standard structure; and (ii) a PAC Executive Committee, comprised of at least 1 representative from each stakeholder group on the PAC;

(b) 11 project workgroups, one for each DSRIP project; and

(c) 7 functional committees: (i) Clinical; (ii) Finance; (iii) Community Needs Assessment and Outreach; (iv) HIT and Biomedical Informatics; (v) Workforce; (vi) Compliance; and (vii) Audit.

To secure the participation of North Shore LIJ Health System ("NSLIJ"), a health system with 2 hospitals in western Suffolk, the PPS agreed with NSLIJ that there will be two hubs within the PPS: (i) one associated with NSLIJ ("NSLIJ Hub"); and (ii) one associated with SBUH ("SB Hub," and together with the NSLIJ Hub, the "Hubs"). Each Hub will be comprised of the associated health system and any coalition partner of the PPS that elects to join the Hub. Each Hub will develop its own operating plans and policies for implementing the DSRIP projects in the Hub in a manner that is consistent with the PPS implementation plan. Coalition partners need not be exclusive to one Hub and may participate in more than one Hub.

The Delegated Model was chosen over the Collaborative Contracting model because it enables representatives of key stakeholders to participate not only in advisory committees but also in the governance body having actual decision-making authority over the PPS – the BOD. Empowering the stakeholders to participate in the BOD will enable the PPS to make more effective decisions and to further the legitimacy of the BOD's decisions with the coalition partners. The Fully Incorporated Model was not feasible at the present time due to the wide diversity of coalition partners and their lack of historical experience in working together.

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: **16_SEC021_DSRIP Application Org Chart v2.ppt**

Description of File

Governance Table of Organization

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***Structure 2:**

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

The establishment of the BOD as a governing body that is dedicated and unique to the PPS offers several advantages in ensuring the adequate governance and management of the PPS:

(i) It allows the responsibilities of the BOD to be dedicated and limited to the governance of the PPS. This ensures that the members of the BOD do not have broader responsibilities to any of the PPS participants that could potentially subject them to competing demands for their loyalty or attention. Further, it enables the BOD's members to be held accountable to the PPS's stakeholders solely on their management of the PPS.

(ii)Moreover, it allows for the presence of representatives from critical stakeholder groups on the actual decision making body of the PPS.

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As discussed below, nearly half of the BOD is composed of members who are not affiliated with SBUH and who represent a stakeholder group that is critical to the PPS's success, and approximately 20% of the initial BOD is composed of physicians. The inclusion of representatives from such stakeholders on the BOD will improve the BOD's decision making by helping it consider issues from multiple viewpoints. As such, it will further the legitimacy of the BOD's decisions with the coalition partners.

The size of the initial BOD has been limited to 21 directors. This ensures that the BOD will have a sufficient number of positions to include a broad range of stakeholders and other individuals with the skills, experience, and qualities required to effectively manage its workload. At the same time, it is not so large as to prevent each director from contributing effectively or as to prevent the BOD from making decisions on a timely basis.

The 3 types of stakeholder committees (the PAC, the PAC Executive Committee, and the 11 Project Workgroups) will help ensure that the PPS's stakeholders have forums to engage in collaborative decision-making, develop shared goals that drive their collaborative activities, and build mutual trust and respect for each other. Through these committees, the stakeholders will have the means to develop recommendations and effectively influence the BOD's policies on the issues that are most critical to the achievement of the DSRIP goals.

The BOD's 7 functional committees will assist in carrying out its workload in key functional areas such as clinical, financial, and IT governance and provide additional opportunities for coalition partners to participate in the PPS's management. Each such committee will be composed of 6 to 15 members, intended to be large enough to include representatives from key stakeholder groups with expertise in the subject matter of the committee, but no so large as to be unwieldy. Each committee will be charged with assisting the BOD in developing comprehensive and concrete plans regarding the relevant areas of focus and will also assist the BOD in overseeing the development, implementation, monitoring, and evaluation of plans.

The Hub structure is necessary to secure NSLIJ's participation in the PPS. Subject to compliance with DSRIP requirements and the PPS Implementation Plan, the NSLIJ Hub may develop its own operational, financial, clinical, and data sharing policies, and NSLIJ's participation in the PPS will ensure that such policies are aligned with those of the SB Hub in a manner that effectively serves Suffolk's populations and the achievement of the DSRIP goals.

The PPS will maintain a leadership and management structure that can manage both clinical and administrative systems. The PPS's operations, including its project management office (PMO), will be managed by the CEO of the IPA. The CEO will be accountable to the BOD for meeting the goals of the PPS, as his or her appointment and removal are under the control of the BOD, subject to the approval of SBUH. Clinical oversight will be managed at the Hub level by a CMO appointed for each Hub.

***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 BOD will maintain a Clinical Committee composed of 6 to 15 members. The members will be physicians and other leaders who are selected from the coalition partners and are representative of the PPS's stakeholders, including primary care physicians, specialist physicians, behavioral health, hospitals, and other provider types. It will advise the BOD in developing, implementing, overseeing, and updating a quality assurance and improvement program that encompasses the following:

-Standards of clinical care delivery promoting evidence-based medicine, patient engagement, and coordination of care (including structures, processes, and outcomes), as necessary to accomplish DSRIP goals and objectives;
-Measuring and reporting on the partners' performance with respect to such standards;
-Reviewing partners' performance on such standards;
-Determining, based upon the clinical performance evaluation process, which areas of care delivery should be the focus of improvement efforts;
-Developing remedial measures for low performing partners; and
-Working with the Finance Committee to develop pay-for-performance agreements.

The Committee also will identify best practices for clinical improvements in the project areas and promote the spread of these improvements to achieve the transformational changes sought under DSRIP. It will aid in making such improvements key strategic initiatives, training clinical leaders for implementation of such improvements, assisting the partners in embedding such improvements in

their operations, and promoting awareness of evidence of success of the improvements.

While clinical outcomes and objectives will be set by the BOD in consultation with the Clinical Committee, the NSLIJ Hub may adopt its own policies regarding clinical structures and processes as necessary to address differences in implementation of the projects in its own Hub. The NSLIJ Hub clinical policies will be aligned with those of the SB Hub as necessary to achieve the DSRIP goals.

***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 BOD will conduct reviews of the performance of the PPS's governance bodies not less than annually. In evaluating the performance of such bodies, the BOD will obtain feedback from the members of such bodies as well as the coalition partners, including by requesting them to complete evaluation surveys and reviews. The performance reviews will evaluate matters such as the governance body's contribution to the achievement of the DSRIP goals, the governance body's effectiveness in making decisions or recommendations on a timely basis, and the inclusiveness, transparency, and accountability of the governing body's processes. Such performance reviews may indicate that a change in the governance structure is necessary to increase its effectiveness.

In addition, it is anticipated that the organizational structure will evolve as each Hub begins to engage in new functions relating to the furtherance of clinical integration within the Hub. As discussed above, the Hub structure was created in order to secure the participation of NSLIJ. It is intended that the coalition partners participating in each of the Hubs become more and more clinically integrated with each other during the years of the DSRIP Program. It is anticipated that each Hub will evolve over time to engage in new functions that further such clinical integration, such as value-based contracting with Medicaid managed care organizations. It is also intended that the two Hubs align with each other on care coordination and clinical data sharing matters as necessary to effectively serve patients who obtain services from providers in both Hubs and to achieve the PPS's overall DSRIP goals. As such, the governance structure may need to evolve as each Hub begins to engage in payor contracting and the two Hubs grow increasingly aligned on clinical and data sharing matters.

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.

Members - The BOD is comprised of 21 directors. 11 of the directors are representatives of SBUH having expertise in various subject matter areas that are critical to the success of the PPS. The remaining 10 directors are comprised of individuals not affiliated with SBUH who serve as representatives of the following stakeholders:

(i) Primary Care – 1 member

(ii) Behavioral Health – 1 member

(iii) Home Health – 1 member

(iv) Patients – 1 member

(v) Long Term Care – 1 member

(vi) Community-Based Organizations – 1 member

(vii) Hospitals and Health Systems – 4 members (2 for NSLIJ, 1 for Brookhaven Hospital, and 1 for East End Health Alliance).

All of the above positions have been filled.

Roles and Responsibilities - Each member of the BOD is entitled to one vote on all matters that come before the BOD. One of the directors representing SBUH will be appointed to serve as the Chair of the BOD.

Regarding the committees, the PAC and the Project Workgroups have been created, and the PPS will create the other committees by 3/2015. Except for the PAC, each committee will have from 6-15 members. Each member will be entitled one vote on all matters that come before the committee.

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***Process 2:**

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

To select the members of the BOD, the PPS considered the potential of the various types of stakeholders to contribute to the success of the projects selected under DSRIP, based on factors such as the stakeholder's role within the continuum, population health management resources and capabilities, and other such factors. In addition, the PPS held a series of informal focus group meetings with key stakeholders across the continuum of care to assist it in identifying the types of stakeholders to be represented on the BOD as well as potential nominees who would best represent the various types of stakeholders. The stakeholders consulted with during such process included FQHCs, behavioral health providers, unions, hospitals, SNFs, and other stakeholders across the care continuum.

Based on such analysis and stakeholder input, the BOD identified the types of stakeholder groups to be included on the BOD. 10 of the 21 available BOD positions were designated for representation by stakeholders not affiliated with SBUH. To provide for the majority of the BOD to be controlled by SBUH as the lead provider, the balance of the positions were designated for SBUH and its affiliates.

To select the individual representing each stakeholder group on the BOD, SBUH designated a coalition partner who is representative of the stakeholder group and granted such coalition partner the right to nominate an individual to serve in such capacity, described as follows:

Stakeholder Group: Primary Care Providers
Nominating Organization:Hudson River HealthCare
Director Name: James Sinkoff

Stakeholder Group: Behavioral Health Providers
Nominating Organization:Long Island Behavioral Alliance Corp.
Director Name: Karen Boorshtein, LCSW

Stakeholder Group: Home Health Providers
Nominating Organization:Dominican Sisters CHHA
Director Name: Mary Zagajeski

Stakeholder Group:Patients
Nominating Organization: Association for Mental Health and Wellness
Director Name: Michael Stoltz, LCSW

Stakeholder Group:Long Term Care Providers
Nominating Organization:Nesconset Center for Nursing
Director Name: Robert Heppenheimer

Stakeholder Group: Community-Based Social Service Agencies
Nominating Organization:Health & Welfare Council of Long Island
Director Name:Gwen O' Shea

Stakeholder Group: Hospitals and Health Systems
Nominating Organization: NSLIJ
Director Name: Jerrold Hirsch,Jeffrey A. Kraut

Stakeholder Group:Hospitals and Health Systems
Nominating Organization:Brookhaven Memorial Hospital Medical Center
Director Name: Brenda Farrell

Stakeholder Group:Hospitals and Health Systems
Nominating Organization:East End Health Alliance
Director Name: Michael O' Donnell

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The 11 directors designated by SBUH as its representatives on the BOD were selected based on their demonstrated leadership capabilities in key functional areas of critical importance to the PPS's abilities to achieve its DSRIP goals. These directors include (i) the Dean of Stony Brook University School of Medicine, (ii) the most senior executive officers of SBUH, including its CEO, CFO, CIO, and COO, and (iii) SBUH's clinical and administrative leaders in key clinical areas, such as behavioral health.

The PPS sought to include a significant number of physicians on the BOD. To such end, 20% of the individuals selected to serve as the initial directors are physicians.

The PAC is comprised of representatives of the coalition partners who are selected in accordance with the standard structure established by DOH in the DSRIP FAQs, as described below. The members of the other committees will consist of directors, PAC representatives, and other individuals selected from among the coalition partners and community stakeholders by the BOD from time to time.

***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.

The BOD includes reps from stakeholder groups anticipated to have the most impact on the projects. In addition, each coalition partner was encouraged to appoint representatives to the PAC, and the PAC will maintain an Executive Committee comprised of 1 rep from each stakeholder group. The BOD has sought recommendations from the PAC on the decisions most critical to the achievement of the DSRIP goals (including org. structure, CNA, project selection, and funds flow), and it will continue to do so throughout DSRIP. The BOD has encouraged each partner to participate in the Project Workgroup that has been established for each selected DSRIP project. The BOD relied on the Project Workgroups in developing the DSRIP Project Plan, and it will continue to seek their assistance in overseeing the implementation of the projects. Moreover, each additional committee (i.e. clinical, finance, HIT, etc.) will include representatives from the stakeholder groups making up the coalition partners.

***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 coalition partners will have a contractual relationship with the IPA through the participation agreement or similar agreements. The coalition partners will be represented in the PPS's governance as described above and it will encourage their active participation in such governance. In addition, the PPS will proactively promote their engagement in the PPS's programs through robust communication and engagement strategies.

The PPS will allocate for use by community-based organizations (CBOs) a portion of the funds distributable under DSRIP to non-safety nets. It will use such funds to assist CBOs in expanding those supportive services that they offer to Medicaid and uninsured populations that will contribute to the success of the projects. As such, the PPS may contract with CBOs to offer their services to a greater number of Medicaid and uninsured individuals, to expand the types of services offered to such individuals, or to improve the quality of their services.

***Process 5:**

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

The PPS sought to develop a "bottom-up" process of decision-making. The foundations for such "bottom-up" process are the governance bodies having the broadest degree of direct participation by the coalition partners, namely the PAC (including the PAC Executive Committee) and the Project Workgroups. Each of these bodies is intended to serve as a forum for coalition partners to engage in deliberation and collaborative problem solving through informed and inclusive processes so that those stakeholders who can impact the DSRIP objectives can make decisions in a collaborative manner and build trust and mutual respect for each other. The BOD will encourage such bodies to engage in deliberations and develop recommendations regarding the most critical issues facing the PPS, and it will consider all such recommendations to ensure that the BOD's decision-making is guided by them.

Decision-making authority is vested in the BOD. Each director on the BOD is entitled to one vote on all matters that come before the BOD. Ordinary decisions may be made upon the affirmative vote of a majority of the directors.

Certain major decisions require the vote of a supermajority of the BOD and the approval of SBUH as the lead. Decisions subject to

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supermajority vote are limited to major items such as funds flow, project selection, and budgets. A supermajority vote requires approval by 2/3 of the BOD, which must include approval by an NSLIJ director; provided, however, that the NSLIJ director approval need not be obtained if the approval of at least 15 directors is obtained. Decisions subject to approval by SBUH include those customarily included in the reserved powers of a sole member of an LLC, such as those relating to the sale of the company or the incurrence of debt.

***Process 6:**

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

The BOD will engage in a collaborative process to achieve consensus. If a disagreement arises among the stakeholders serving on the stakeholder committees (i.e. the PAC, the PAC Executive Committee, or Project Workgroups) or the members of the BOD, the BOD may assign the matter to one of its committees to consider it and make recommendations. If the relevant committee is unable to develop a recommendation that is accepted by the BOD on a consensus basis, a decision may be made by the BOD upon the affirmative vote of a majority of the directors; provided, however, that certain major decisions must be made upon the affirmative vote of a supermajority of the directors, as described above. Due to the odd number of directors on the BOD, it is not anticipated that either a majority vote or a supermajority vote could result in a deadlock. The PPS will consult with DOH to help to resolve disputes among the directors if necessary.

***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.

Full transparency in its governing process is a critical component of the PPS's efforts to build and maintain trust among the PPS and its coalition partners. To such ends –

Meetings of the PPS's governance bodies are open to coalition partners. To encourage their attendance, the dates and locations of the meetings will be made available to coalition partners through the PPS's website. A closed executive session may be held at any meeting in the governance body's discretion with respect to matters of a confidential or proprietary nature.

All meeting materials will be maintained by the PPS at its principal office for inspection by the coalition partners. In addition, they will be made available for viewing by the coalition partners on the PPS's website and upon request. Key outcomes of governance meetings will be communicated to the coalition partners through newsletters, email listservs, and other communication channels maintained by the PPS as part of its communications plans.

***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.

(a) Communications Strategies. The BOD will maintain a Community Needs Assessment and Outreach Committee charged with promoting stakeholder engagement, including Medicaid members. The Committee will develop a plan for engaging stakeholders through newsletters, fact sheets, email listservs, webinars, school fairs, community lectures, community-wide contests, and other public meetings and events.

(b) Coalition Partner Enlistment. Coalition partners will post or distribute at their facilities informational materials relating to the PPS's stakeholder engagement efforts.

(c) Website. The PPS's website will include a webpage dedicated to stakeholder engagement.

(d) Participation in Governance. Stakeholders, including patient advocates, will be represented on the PAC, the PAC Executive Committee, and the BOD, where they will have a meaningful voice in the governance of the PPS and function as liaisons with the stakeholder groups they represent.

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:

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***Committee 1:**

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

The PAC grew out of meetings held in April through June 2014 with a broad range of potential partners, including providers across the care continuum, unions, and CBOs. During those months, SBUH engaged in extensive outreach efforts to promote awareness, participation, and engagement of such potential partners and invited them to participate in the PPS. Such efforts included several large in-person meetings open to all potential partners, a series of small in-person meetings with small groups of the same stakeholder type (i.e. behavioral health organizations, SNFs, unions), webinars, and surveys of potential partners.

In July 2014, each potential coalition partner was requested to complete a survey identifying its organizational and workforce representatives for the PAC. The PAC was formally established in accordance with the DOH standard structure in August 2014, as soon as SBUH was awarded the Design Grant.

In-person meetings of the PAC have been held monthly since August. The meetings have been attended by hundreds of representatives and have been held at a large, fully equipped, hotel conference room conveniently located in central Suffolk. All meetings have been video recorded. Meeting materials/ recordings are available on the PPS's website.

At each PAC meeting, the PPS sought to go beyond "town-hall" style meetings and to employ deliberative engagement processes intended to facilitate deliberation of issues among the PAC members, reaching of consensus among the PAC members, and development of concrete recommendations. Examples of issues that were deliberated include the CNA, project selection, funds flow, care management, HIT, and project plans. Typically, a meeting begins with presentations containing the information needed by the PAC members to engage in informed deliberation. The PAC members then are grouped at round tables of 10 (or less) and requested to deliberate the issues at each small table. The outcomes of the deliberations are then reported back to the larger PAC and are developed into concrete recommendations, which are then reported back to the BOD.

In addition, the PPS formed 11 Project Workgroups, 1 for each DSRIP project, each of whose charge has been to develop a plan for the project. The workgroups were open to any interested partner, and each workgroup has been holding weekly or bi-weekly meetings since September.

***Committee 2:**

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

The PAC has served as a forum for the partners to deliberate, achieve consensus, and develop recommendations on the decisions most critical to the achievement of the DSRIP goals (including the organizational structure, the CNA, project selection, and funds flow), and it will continue to do so throughout DSRIP. The PPS will routinely share performance data with the PAC. Continued regular meetings of the PAC held throughout DSRIP will also help ensure that communication between the PPS and its partners is constant and transparent. The BOD will consider all recommendations/ input received from the PAC.

In addition, the BOD will form a PAC Executive Committee, which will be comprised of at least 1 representative from each of the stakeholder groups on the PAC, initially totaling 39 members. The members of the Executive Committee will be selected from among the PAC members based on a vote by the PAC members. The Executive Committee will serve as a smaller, streamlined version of the PAC.

***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).

At the August PAC meeting, the PPS presented to the PAC a proposal for an organizational structure for the PPS. Such proposal was based on input received by the PPS in meetings previously held in May–July with key stakeholders (including FQHCs, behavioral health providers, SNFs, and unions) about the organizational structure. Based on feedback from the August PAC meeting, the final organizational structure for the PPS was developed.

In connection with the CNA, the PAC assisted in identifying participants for surveys of key informants and patients. At the September PAC meeting, the CNA results were comprehensively presented to the PAC. During such PAC meeting, the PPS instituted a process enabling the PAC members to deliberate the selection of projects based on the CNA and vote on the selection of projects. The projects recommended during that meeting were adopted by the PPS.

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***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.

Representatives to the PAC are chosen in accordance with the standard structure described in DOH's DSRIP FAQs. Membership on the PAC is open to representatives from any organization desiring to join the PPS as a coalition partner, including providers from across the continuum of care and community-based organizations. In addition, the PAC will include several representatives for Medicaid beneficiaries (including separate representatives for Hispanic speaking beneficiaries and beneficiaries with behavioral health issues), community stakeholders (including local politicians and school superintendents), and subject matters experts in HIT and biomedical informatics.

Section 2.4 – Compliance:

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

***Compliance 1:**
Identify the designated compliance staff member (this individual must not be legal counsel to the PPS) and describe the individual's organizational relationship to the PPS governing team.

The PPS will engage a compliance officer ("CO") who is not legal counsel to the PPS and is free of influence from the PPS's leadership and management. The CO will oversee the implementation and operation of the compliance program in coordination with the BOD and its Compliance Committee. The CO will report directly to the BOD and the Compliance Committee. The CO will provide the BOD with periodic reports regarding the implementation and effectiveness of the compliance plan and keep the Board informed about compliance issues that arise form time to time under the compliance plan.

***Compliance 2:**
Describe the mechanisms for identifying and addressing compliance problems related to the PPS' operations and performance.

The CO and Compliance Committee will perform reviews and monitoring activities, including reviewing reports, assessments and complaints and conducting audits to address regulations, risk areas and compliance problems relating to the PPS. The CO will work with legal counsel, outside auditors and consultants to respond to and correct problems, conduct investigations, implement corrective actions such as sanctions, report to government agencies, develop revised policies and conduct supplemental training.

Each partner's compliance officer will be responsible for reporting compliance issues to the CO and cooperating with any investigation or remediation. In addition, NSLIJ will be responsible for implementing within the NSLIJ Hub an effective compliance program that is consistent with the requirements of the PPS's compliance program, for reporting to the CO any compliance issues relating to the NSLIJ Hub, and for cooperating with any investigation or remediation relating to the NSLIJ Hub.

***Compliance 3:**
Describe the compliance training for all PPS members and coalition partners. Please distinguish those training programs that are under development versus existing programs.

PPS staff, coalition partners, and respective personnel will receive at least one hour of mandatory annual training on compliance policies. The training will include information about the federal and state laws that are implicated by the PPS's activities under DSRIP. Additional training programs will be developed for specific personnel or groups based upon job functions or identified compliance issues and risk areas. All training programs are currently under development and will be integrated with any existing training programs of PPS coalition partners.

***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.

Information regarding how Medicaid beneficiaries and uninsured community members may report compliance complaints will be available on the PPS's website and at the offices of the coalition partners. Such information will be made available in multiple languages.

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Compliance complains may be filed (i) through the Compliance Hotline, a toll-free telephone number maintained by the PPS for anonymous reporting of compliance issues, (ii) through the PPS's website, (iii) or by contacting the CO's office by mail, email, fax, or telephone.

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.

In an effort to ensure shared governance over financial matters relating to the PPS, SBUH has delegated decision-making authority over financial governance to the BOD, subject to certain reserved powers of SBUH as the lead provider (such as rights to approve changes to funds flow and budgets). To assist it in carrying out its financial governance functions, the BOD will maintain a Finance Committee. In addition, each Hub will be permitted to adopt its own financial policies and controls that would be applicable only to their own respective hubs.

Moreover, the PPS will maintain an Audit Committee to oversee the organization's financial and auditing procedures, including the monitoring of quality and performance metrics. Such committee will be comprised of independent members of the BOD, who are intended to be free of influence from management and others.

***Organization 2:**
Please provide a description of the key finance functions to be established within the PPS.

The BOD will manage and oversee the following finance functions:

(a) Develop accounting policies and establish and maintain internal controls that will, among other things, initiate, record, process, and report transactions (as well as events and conditions) relating to the use and distribution of DSRIP funds, including segregation of duties and a structured system of checks and balances;

(b) Develop methodologies for use and distribution of DSRIP funds, provided that each Hub may develop its own methodologies that are compliant with DSRIP for distribution among the Hub's participants of that portion of the DSRIP funds that is allocable to the Hub;

(c) Develop capital budgets and operating budgets for the project management office; and

(d) Develop financial plans for the PPS.

Consistent with the intention for payor contracting to occur at the Hub level, each Hub Lead will be responsible for developing value-based payment methodologies that support and are reasonably necessary to further the abilities of the Hub to achieve integrative efficiencies.

***Organization 3:**
Identify the planned use of internal and/or external auditors.

The Audit Committee will be charged with providing guidance to the BOD on matters relating to audit and risk management. The BOD will use both internal and external auditors to audit the IPA's books and records to ensure the IPA's compliance with its financial policies and controls. The BOD will employ external, independent auditors to audit the books and records of the PPS's coalition partners on a confidential basis to ensure compliance with such financial policies and controls.

***Organization 4:**
Describe the PPS' plan to establish a compliance program in accordance with New York State Social Security Law 363-d.

The PPS will develop a corporate compliance program comprised of the elements set forth in New York State Social Security Law Section 363-d. A designated compliance officer (CO) will oversee the implementation and operation of the compliance program, and all PPS

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personnel, members and partners will be required to cooperate with the PPS' compliance activities. It is anticipated that the CO will complete the implementation of the program by March 15, 2015.

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.

The BOD, with the assistance of the Clinical, Finance, and IT Committees, will develop performance measures for the coalition partners that are consistent with the DSRIP goals. The PPS will require coalition partners to report data regarding their performance on such measures. The BOD will monitor such data and utilize the Medicaid Analytics Performance Portal ("MAPP") to evaluate the performance of the coalition partners on the PPS's performance measures. Based on such data, the PPS will prepare reports regarding the performance of the coalition partners on the PPS's performance measures, including performance dashboards and scorecards, to be used by the BOD, with the assistance of the Clinical Committee, in monitoring their performance.

***Oversight 2:**
Outline on how the PPS will address lower performing members within the PPS network.

The performance reports will be distributed to coalition partners on a consistent basis, not less than quarterly, to provide feedback to each coalition partner on its performance. In addition, such data and performance reports will be used by the Clinical Committee to develop corrective action plans for lower performing members and to conduct quality assessment and improvement activities. NSLIJ will be responsible for developing and submitting to the BOD for approval corrective action plans for coalition partners within the NSLIJ Hub.

Quality improvement actions will be considered and adopted using a systemic and organized framework for improvement (such as that found in the 'Plan, Do, Check, Act' methodology). Based on such analyses, the Clinical Committee may recommend that the BOD take actions to improve the performance of the PPS and its coalition partners such as, but not limited to: re-education of lower performing coalition partners in policies and procedures; re-assessment of staff allocation and activities; mid-course corrections; design of new services; improvement of existing services.

***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.

The remedial processes and penalties for the coalition partners (and their providers) who fail to meet such performance measures will include the following, depending on the severity of the deficiency or non-compliance:

(a) Periodic reports of recommendations to improve performance. The PPS will issue to the coalition partner periodic reports containing recommendations for improvement of performance. The frequency of such reports will be determined by the Clinical Committee, but will be issued not less than semi-annually.

(b) Onsite interaction with the Chief Medical Officer. The Chief Medical Officer may conduct on-site visits and otherwise communicate with and monitor the coalition partner to address deficiencies in performance or non-compliance, as necessary.

(c) Corrective Action Plans. The PPS will issue to the coalition partner written notices specifying deficiencies in performance and describing corrective action that it must take to remedy the deficiencies. As described above, NSLIJ will be responsible for developing and submitting to the BOD for its approval corrective action plans for coalition partners within the NSLIJ Hub.

(d) Financial Disincentives. Deficiency in performance may make the coalition partner ineligible to receive DSRIP funds under the funds flow methodologies adopted by the PPS and the applicable Hub. In addition, the PPS may seek to impose financial penalties on the coalition partner by withholding DSRIP funds otherwise distributable to the coalition partner until the deficiency in performance is

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remedied.

(e) Termination. The PPS may seek to terminate the coalition partners from participation in the PPS pursuant to and in accordance with the terms and conditions of their applicable agreements with the PPS and DOH's DSRIP policies and procedures. With respect to the NSLIJ Hub, the PPS may seek to require NSLIJ to terminate coalition partners from participation in the NSLIJ Hub in accordance with the terms and conditions of the agreement between NSLIJ and the PPS.

***Oversight 4:**

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

The PPS will maintain a no-wrong door policy, where Medicaid beneficiaries and their advocates may provide such feedback by any means desired, including calling the Compliance Hotline and submitting a letter to the PPS's management. In addition, the PPS will maintain on its website a webpage enabling Medicaid beneficiaries and their advocates to provide feedback about providers. All such feedback will be provided to, and reviewed by, the PPS's management, the Clinical Committee, and the BOD.

***Oversight 5:**

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

A current list of the PPS's providers will be maintained on the PPS's website and will be accessible to the PPS's Medicaid beneficiaries and their advocates. Such list will be updated as providers are removed or added to the PPS.

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.

The CNA was conducted from July 15- Sept. 15 in accordance with the DOH Guidance. It has three parts: population and key informant surveys conducted by Professional Research Consultants, Inc. (PRC); healthcare delivery system assessments conducted by xG Health and Stony Brook Medicine (SBM); and an analysis of secondary data (health service utilization; disease incidence and prevalence; and health related behaviors). Information and insights were synthesized, summarized, and presented to the PAC on 9/15/14.
For the population survey, telephone interviews (landline and cell phone) were used to reach two groups: the "Total Population"-a random sample of 400 residents aged 18+; and the "Target Population"-500 Medicaid/uninsured residents. Trained interviewers questioned respondents (in English or Spanish) on topics including demographics, health status, access barriers, specific disease conditions, and nutritional and weight status. The survey was quite detailed and took approximately 30 minutes to complete. By including both the "Target" and the "Total" populations, we were able to describe and quantify health disparities between payer groups. This was supplemented by an online Key Informant survey which solicited input from health professionals, social service providers, community leaders and interested parties. Participants were chosen based on PPS member recommendations and their expertise related to specific populations and health concerns. Final participation included 118 respondents.
To assess capabilities and gaps in the healthcare delivery system, xG Health conducted a PPS-wide general survey of key capabilities, processes, practices and interviewed major providers across the continuum. A SBM team also conducted six additional targeted surveys (workforce; project-specific characteristics, member operating characteristics and capabilities; technology; cultural competency/health literacy; and SNF processes of care) that were essential to optimal PPS planning.

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

A robust secondary data analysis leveraged an internal team with expertise in clinical data management, biomedical informatics, public health, and planning. This began with an extensive review of the data released on the public NYSDOH data portal and the DSRIP performance site. A PubMed search identified published studies associated with the target population. Public health resources included County specific data from the NYS Prevention Agenda and the Suffolk County Dept. of Health Services Community Health Assessment 2014-2017. Additional sources used in the CNA included: the Behavioral Risk Factor Surveillance System (BRFSS), NY Vital Statistics, and the American Community Survey estimates. Dashboards (PQI/PDIs; PPVs; and PPR chains) were analyzed for the County. Spatial and comorbidity analysis were performed on the NY SPARCS Limited Data Set. PQI/PDI inpatient discharges were calculated based directly on SPARCS inpatient discharges using AHRQ software. Comorbidities associated with inpatient and ED visits were made using clinical groups defined by AHRQ's CCS groupers. Where countywide data was not available, analysis of Stony Brook Medicine (SBM) data was used as a proxy since SBM is the largest safety net hospital in Suffolk County.

The vendor that conducted our primary research, Professional Research Consultants, Inc. (PRC), also reviewed available datasets

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including the most recent BRFSS Prevalence and Trend data, Healthy People 2020, and state level vital statistics. Nationwide risk factor data, which are also provided in comparison charts within the larger primary research report, were taken from the 2013 PRC National Health Survey; the methodological approach for the national study was identical to that employed in this assessment, and these data are generalizable to the US population with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

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	11	8
2	Ambulatory surgical centers	24	7
3	Urgent care centers	45	1
4	Health Homes	3	3
5	Federally qualified health centers	7	7
6	Primary care providers including private, clinics, hospital based including residency programs	1272	732
7	Specialty medical providers including private, clinics, hospital based including residency programs	3468	1389
8	Dental providers including public and private	1174	166
9	Rehabilitative services including physical therapy, occupational therapy, and speech therapy, inpatient and community based	419	260
10	Behavioral health resources (including future 1915i providers)	116	68
11	Specialty medical programs such as eating disorders program, autism spectrum early	52	3
12	diagnosis/early intervention	0	0
13	Skilled nursing homes, assisted living facilities	42	64
14	Home care services	99	27
15	Laboratory and radiology services including home care and community access	103	28
16	Specialty developmental disability services	74	74
17	Specialty services providers such as vision care and DME	251	2
18	Pharmacies	159	149
19	Local Health Departments	1	0
20	Managed care organizations	12	2
21	Foster Children Agencies	10	4
22	Area Health Education Centers (AHECs)	0	0
23	Pain Management and Palliative Care	13	7
24	Psychologists	872	305
25	Social Workers	2349	1175
26	Licensed mental health counselors and behavior analysts	375	303

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

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***Infrastructure 2:**

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

While Suffolk County has many assets, the provider capacity and distribution is not adequate for addressing the challenges related to population health needs. In many cases, there is not only an inadequate supply but also a geographic misalignment of providers with vulnerable populations. The provider composition is heavily weighted toward inpatient care and there are many overlapping services between hospitals. From the standpoint of assessing the alignment of services with population needs, providers have been assigned to one of seven submarkets that generally reflect hospital service areas: the Southwest, the Northwest, the Core, the Central South, the Central East, the North Fork, and the South Fork. While the eleven Suffolk hospitals are distributed throughout the submarkets, other providers tend to concentrate in more economically prosperous population centers. Most services are concentrated in the more densely populated Core and Southwest regions though many of the Medicaid and uninsured residents live in the Central East and North Fork portions of the County. For example, there are no freestanding ambulatory surgical centers in the East, while both the Northwest and Southwest have two each. A comparison of supply and demand for primary care physicians by submarket indicates shortages in all submarkets. (i) Rehabilitative services and ancillary and specialty providers also tend to be concentrated in the Core, Southwest, and Northwest. Moreover, many providers do not accept Medicaid patients and the uninsured find cost to be a substantial barrier to access.

A review of inpatient capacity and hospital occupancy rates across the eleven Suffolk County hospitals demonstrates that there is excess inpatient capacity that should be repurposed to meet patient care needs on an outpatient basis. Hospital occupancy rates range from 46% to over 90% and several hospitals are under severe financial strain. A survey of Key Informants indicated that behavioral healthcare is the most difficult to access, followed by substance abuse treatment, primary care, specialty care, dental care, chronic disease care, elder care, urgent care, pain management, palliative care, and safe housing. (ii) Additional capacity is needed in all these areas along with better care management and coordination and an increased emphasis on health promotion. Existing primary care providers also need to evolve to more advanced practice models (e.g. EHR Meaningful Use and NCQA PCMH recognition). Fewer than 50% now have any level of PCMH certification.(iii) Clinical staff should be allowed to function at the top of their licenses. An expansion of hours (few currently have evening and weekend hours) would help in alleviating access barriers, and technological improvements would enable automated risk stratification, alerts, and monitoring of utilization patterns and quality metrics. Staffing enhancements such as dedicated care managers embedded in PCP practices would improve patient care, assist with navigation, and aid in managing utilization.

Section 3.3 - Community Resources Supporting PPS Approach:

Description:

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

***Resources 1:**

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

#	Resource Type	Number of Resources (Community)	Number of Resources (PPS Network)
1	Housing services for the homeless population including advocacy groups as well as housing providers	34	5
2	Food banks, community gardens, farmer's markets	216	10
3	Clothing, furniture banks	16	0
4	Specialty educational programs for special needs children (children with intellectual or developmental disabilities or behavioral challenges)	8	1
5	Community outreach agencies	46	4
6	Transportation services	19	0
7	Religious service organizations	145	0
8	Not for profit health and welfare agencies	9	1
9	Specialty community-based and clinical services for individuals with intellectual or developmental	34	12

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#	Resource Type	Number of Resources (Community)	Number of Resources (PPS Network)
	disabilities		
10	Peer and Family Mental Health Advocacy Organizations	25	5
11	Self-advocacy and family support organizations and programs for individuals with disabilities	0	0
12	Youth development programs	26	2
13	Libraries with open access computers	57	0
14	Community service organizations	113	25
15	Education	16	4
16	Local public health programs	1	1
17	Local governmental social service programs	33	5
18	Community based health education programs including for health professions/students	10	3
19	Family Support and training	53	6
20	NAMI	1	1
21	Individual Employment Support Services	28	2
22	Peer Supports (Recovery Coaches)	20	6
23	Alternatives to Incarceration	1	0
24	Ryan White Programs	1	0
25	HIV Prevention/Outreach and Social Service Programs	17	0

***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.

CBOs can provide support services such as care transitions, chronic disease management, medication management, nutrition support, transportation, home and family assessments, health benefits counseling, and caregiver support. They can also be effective in addressing many of the social determinants of health (safe housing, education, job opportunities, transportation, public safety, freedom from discrimination, alleviation of poverty, etc.) To date in Suffolk County, such services have been fragmented for populations in certain areas. The creation of the PPS will provide a much greater opportunity for assuring that these services are directed to the populations in need.

In looking at and mapping the inventory completed as part of the CNA, we see that despite the large number of community resources, there are relatively few in areas with high Medicaid and uninsured populations. This reflects the same type of misalignment of resources in relation to needy populations as seen with provider resources. A population that stands out as having particularly limited services is the disabled, particularly blind/deaf individuals. Medicaid members in general also lack resources such as family support as well as training and programs for special needs children.

Throughout the County, certain other categories of resources will be added to PPS membership in 2015. These include furniture and clothing banks, libraries, transportation servcies, alternatives to incarceration, and religious entities. In relation to existing resources, other barriers prevent access for populations in need. For example, despite there being a large number of food banks, the hours of operation are limited (i.e., 2 hours once a week). A possible solution would be to ask the various food banks to expand their hours of operation to better accommodate the public. Transportation services are often limited to the towns in which resources are situated and availability of information (i.e., routes) is scarce on websites. Community members find availability of transportation to be particularly challenging, especially on Sundays. Despite there being libraries in most towns, resources may not be available to all community members. Distances from libraries depend on the part of town in which an individual lives; if it's far and there's a lack of transportation, individuals may not be able to use these services.

Housing is also a serious problem for which more resources are needed. Key Informants stressed the importance of improving housing availability: 7 in 10 survey respondents (70.8%) felt that access to housing was a major problem for Medicaid members and uninsured populations. Housing problems relate to: high cost, the behavioral health needs of those looking for housing, the difficulty in finding

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placement, homelessness, undocumented status among residents, segregation, disabilities, and lack of education. (iv) Adding to the housing problem is the finding that homelessness has increased on Long Island, rising 24.9% since 2007.(v) The majority of homeless people have behavioral health problems.

As noted, the PPS will be adding more resources in early 2015.

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:

The County has a total population of 1,492,360 residents. Between the 2000 and 2010 US Censuses, the population increased by 73,956 persons, or 5.2%. This is more rapid growth than statewide but lower than national figures. Census profiles indicate that 23.8% of residents are infants, children and adolescents (age 0-17); another 62.5% are age 18 to 64; and 13.7% are aged 65 and older. In general, these percentages are close to those reported statewide as well as nationally, though Suffolk County is slightly "older" than the state and the nation in terms of median age (39.8 years).(vi) Median age varies by town, ranging from a high of 52.5 years on Shelter Island to a low of 31 years on the Poospatuck Indian Reservation. (vii) The highest youth population under age 18 is in Brentwood, where the greatest numbers of Medicaid/uninsured persons also live. Many of the east end towns have high proportions of elderly age 65+. Countywide, the % age 65+ is expected to increase to 19.3% by 2040.

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

In looking at race independent of ethnicity (Hispanic or Latino origin), 82.0% of residents in Suffolk County are white, less than 8.0% are Black, and the remaining are other races. About 17% of residents are Hispanic or Latino. This is slightly lower than found statewide, but almost identical to that found nationally. Between 2000 and 2010, the Hispanic population in Suffolk County increased by 96,826, or 64.8%. This is proportionally much higher than found statewide and higher than found nationally. (ix) A total of 4.9% of the Suffolk County population age 5 and older lives in a home in which no person age 14 or older is proficient in English (speaking only English, or speaking English "very well"). Certain communities have particularly high Hispanic populations and poor health outcomes, such as Brentwood, where 69% are Hispanic, 48% white, and 16% Black. (x) Brentwood and several other similarly diverse communities are home to many Medicaid and uninsured residents.

***Demographics 3:**
Income levels:

The median household income in Suffolk County was $83,360 in 2011, an increase of 37% from the median income of $61,000 in 2000. (xi) Income varies by town: in Smithtown (the Core submarket), the median income is $106,883 while on the Shinnecock Indian Reservation, it is $29,271. Suffolk County has one of the highest costs of living of any region in the US. Policy makers have determined that $75,000 is the minimum income needed by a family of four for basic necessities. One in five Suffolk families lives below 200% of the FPL. These "near poor" tend to be highly concentrated in communities containing a majority of African American and Hispanic residents: Brentwood, Huntington Station, and Central Islip. Other particularly vulnerable groups in terms of income adequacy are children, senior citizens, persons with disabilities, and those with behavioral health problems. An estimated one-third to one-half of seriously mentally ill residents are poor.(xii)

***Demographics 4:**
Poverty levels:

6.1% of the population (90,093 persons) lives below the federal poverty level. This includes 7.4% of children under 18 (26,092 persons); 5.4% of adults age 25+ (54,170 persons); and 5.6% of seniors age 65+ (10,892 persons). Among whites, the poverty rate is 4.8% vs. 12.9% for African Americans vs. 10.7% for Hispanics. Among female headed households with children, 19.7% live in poverty.(xiii) There is a correlation with education: among adults with a high school degree only, the rate is 6.9% vs. 4.2% of those with an Associate's degree

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vs. 2.3% of those with at least a Bachelor's degree. The zip codes with the lowest incomes levels tend to have higher numbers of Medicaid and uninsured persons. Reflecting poverty or near poverty, 35% of children overall are eligible for the free/reduced lunch program, with the highest numbers of such children in Brentwood (66%), Central Islip (68%), and Huntington (27%). Children in poverty have more cognitive and behavioral difficulties. (xiv)

***Demographics 5:**

Disability levels:

In the American Community Survey, six disability types (difficulties related to hearing, vision, cognition, ambulation, self-care, and independent living) were reported. Respondents who reported any of these are considered to have a disability. The disabled population represents 6.8% of those between the ages of 18 and 64: 6.6% of whites, 10.4% of African Americans/Blacks, and 5.6% of Hispanics/Latinos. For children under 18 years of age, 3.4% are disabled: 2.5% of whites, 4.3% of African Americans/Blacks, and 2.5% of Hispanics/Latinos. Among those who are older than 64, a larger portion (29.5%) are disabled (29.3% of whites, 34.4% of African Americans/Blacks, and 27.7% of Hispanics/Latinos).(xv) Disabled persons are often in poverty; in focus groups held by a local commission, respondents indicated that while government programs often provided enormous supports, the many rules and regulations create unnecessary obstacles that are barriers for getting the services they need.(xvi)

***Demographics 6:**

Education levels:

Among adults age 25+, the educational profile of adults is as follows: Less than 9th grade (45,466 or 4.5%); 9th to 12th grade, no diploma 59,863 (6.0%); High school graduate (includes equivalency) 302,697 (30.3%); some college, no degree 179,200 (17.9%); Associate's degree 88,972 (8.9%); Bachelor's degree 180,177 (18.0%); and Graduate or professional degree 143,401(14.3%). In total, the percent of the population having a high school degree or higher is 89.5% and the percent with a bachelor's degree or higher is 32.4%. (xvii) According the the Suffolk County Health Dept. CHA, educational attainment is lower among minorities - among African Americans/blacks and Hispanics, 15.5% and 30.1% respectively lack a high school degree. Among whites, only 7.8% lack a high school degree. Similarly, a greater percentage of whites than African Americans/blacks or Hispanics have a college degree.

***Demographics 7:**

Employment levels:

In the Suffolk population age 16 and over, the unemployment rate is 6.4%.(xviii) In some subgroups, such as those 20-24, it is much higher at 12.2%. Among Blacks, it is 9.8% and among American Indians and Alaskan natives it is 13.6%. Among Hispanics, the unemployment rate is 8.1%, though this does not include the many undocumented workers. In workplaces, Hispanics still suffer discrimination and marginalization and many have limited English proficiency. In general, a higher percentage of men are unemployed (6.1%) than women (5.6%).

Residents with higher educational levels have higher employment rates. Among those aged 25-64, 83% of those with a bachelor's degree are employed, while among people lacking a high school diploma, only 60.8% are employed. About 70% of workers are employees of private companies, while almost 19% work for local, state, or the federal government. The remaining workers are self-employed or work for non-profit agencies.(xix)

***Demographics 8:**

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

In Suffolk County, the institutionalized population overall totals 11,972.(xx) A particularly high need subset of this group is the incarcerated population. The average daily incarcerated population census is 1,732 persons.(xxi) The Black community is overrepresented in the Suffolk County jail system. African Americans make up about 7% of the total population of Suffolk County but 40% of the total jail population. Over half (54%) of the people detained in jail before trial because they are unable to make bail are Black. The Hispanic/Latino community is also disproportionately represented in the incarcerated population.(xxii) The closure of mental health facilities in Suffolk County has given the criminal justice system fewer options and resulted in more mentally ill people in jail. Incarcerated juveniles represent 5.3% of the overall population.(xxiii) This young population has its own unique problems, including growth and development issues and frequent substance abuse problems.

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

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As necessary, please include relevant attachments supporting the findings.

File Name	Upload Date	Description
16_SEC034_Project 3 b i Question 4c Stony Brook University Hospital - SUFFOLK-PPS.docx	12/22/2014 11:14:48 AM	Project 3bi, Question 4c
16_SEC034_Community Needs Assessment citations.docx	12/15/2014 06:59:18 PM	CNA Citations

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:

Among all racial/ethnic groups, the top ten age-adjusted causes of death are heart disease, cancer, stroke, unintentional injuries, chronic lower respiratory disease (CLRD), kidney disease, septicemia, pneumonia and influenza, drug induced death, and diabetes. The leading causes of premature death are cancer, heart disease, unintentional injury, CLRD, and suicide. Of the causes outlined in HP 2020, the age-adjusted mortality rates in Suffolk are worse than national rates for heart disease, kidney disease, drug-induced deaths, and septicemia. Blacks and whites have a higher total mortality rate than Hispanics, but Blacks and Hispanics have higher rates of premature death. Suffolk exceeds the statewide rate for premature death (22.6% versus 21.9%), but falls below the statewide ratios for Black non-Hispanics/whites and Hispanics/white non-Hispanics. (xxiv, xxv)
Blacks have significantly higher mortality rates than other groups for stroke, coronary heart disease, and diabetes. Whites have higher mortality rates for heart disease overall. Hispanics have higher rates of diabetes mortality.The infant mortality rate among Blacks is more than twice that of whites. (SCDHS CHA 2013-17)

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

Suffolk Medicaid members collectively had 34,944 hospital admissions in 2012. When one considers both primary and secondary diagnoses, CVD was the most prevalent condition. By primary diagnosis, the top five reasons for admission are perinatal, psychiatric disorders, CVD including hypertension, substance abuse, and cancer. Approximately 10% of total admissions are classified as either PQI or PDI. Using two-year averages from the Health Data NY, the greatest number of annual PQI admissions in 2012 was from COPD/asthma (706), followed by Heart Failure (481), and pneumonia (473). For the Adult Composite rates, Suffolk exceeds the statewide rates on the Overall (1.14), Acute (1.22), Chronic (1.09), Diabetes (1.15), and Respiratory (1.16) PQIs. The Suffolk County rate for the Adult Circulatory Composite falls below the statewide rate (.96). (xxvi)
Falls are a leading cause of injury deaths, hospitalizations and ED visits in adults 65 years of age and older.
Both Blacks and Hispanics have higher hospitalization rates than whites for heart disease, stroke and diabetes. These groups also have higher admission rates for short-term complications of diabetes. (SCDHS CHA 2013-17)

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

Suffolk performed better than NYS on Medicaid PPVs, with 36/100 or 86,435 visits (71% of total visits). The highest volumes are from residents of Brentwood, Bay Shore, Riverhead, and Patchogue.(xxvii) Primary drivers are behavioral health (BH), cardiac conditions, asthma and diabetes.(xxviii) Lack of access is paramount: among Medicaid/uninsured residents, 67% report trouble accessing care. For BH services after hospitalization, only 48% of patients receive timely follow-up and 35% don't fill their prescriptions. 31.6% of BH discharges are readmitted within 90 days.(xxix) Regarding PPRs, there were 26,714 "at-risk" admissions within Suffolk County in 2012, which in turn triggered 1,612 PPR chains. PPR rates vary substantially between Suffolk County hospitals. Observed rates range from 12.71 at ELIH to 3.13 at SHH of "at-risk" admissions. The statewide observed rate is 6.73. When risk-adjusted, four out of the 11 Suffolk hospitals have PPR rates above their expected values.(xxx)
There are many short stay (length of stay less than 2 days) admissions in Suffolk County—27% of Medicaid admissions (9,475) were short stay.

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***Challenges 4:**

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

A review of prevalence shows widespread disparities in chronic disease for Medicaid members in relation to the population overall. There are narrowly defined disease hotspots in regions with high racial/ethnic minorities and low average incomes (Brentwood, Central Islip, Patchogue, and Riverhead). Among the uninsured, disease rates are generally higher than private pay populations, but lower than Medicaid members. 67% of Medicaid/uninsured report healthcare access problems, with behavioral health care being the most difficult to access. Adequate housing is a key issue among those with behavioral health problems, and many providers do not accept Medicaid. Other key barriers include cost and lack of transportation.
Below are key prevalence findings from the PRC Population Survey (PPS Primary Research):
-Heart disease affects 6% of the population overall, but 15.6% among Medicaid members.
- Stroke prevalence is 3.6% in the population overall, but 4.3% among Medicaid members.
- Hypertension affects 32% of both the overall and Medicaid/uninsured populations. The latter populations are less likely than the population at large to have had their blood pressure tested. Hypertension is more common among lower income residents.
- Cardiovascular risk factors affect 83.4% of the overall population, but 89.6% of Medicaid/uninsured residents.
- 12.5% of the overall adult population views their mental health as "fair" or "poor." Among Medicaid/uninsured populations, the rate is twice as high at 25.9%.
- Depressive disorders affect 18.7% of the population overall, but 40.2% of Medicaid members. Fewer Medicaid members have sought help.
- Medical and behavioral illnesses frequently coexist. Almost half of individuals in OMH programs with a cardio-metabolic disorder are also prescribed antipsychotics.
- 7.2% of the population overall have been diagnosed at some time with cancer, while among Medicaid members the rate is 10.9%. Incidence rates are highest among whites and lowest in Hispanics. Death rates are highest in Blacks, particularly Black males.
- Chronic obstructive pulmonary disease affects 7.8% of the population overall, but 17.8% of Medicaid members.
- Asthma affects 11% of the overall population, but 16.3% of Medicaid members. The childhood asthma prevalence is 4.5% overall, but 13.3% among children with Medicaid. In the some Suffolk hotspots, it is as high as 17.9%.
- Diabetes affects 11% of the overall population, but 19.3% of adult Medicaid members.
- Kidney disease affects 5.4% of the overall population, but 8.6% of Medicaid members.
- HIV prevalence rates are generally much lower than statewide/national rates, but are highest in non-Hispanic Blacks.

Minority populations are at greater risk for heart disease and stroke. According to Million Hearts, African Americans are at almost twice the risk for having a first stroke than Whites. In addition, African Americans and Hispanics are more likely to die following a stroke than are whites. Low incomes persons are much more likely to suffer from hypertension, high cholesterol, heart attack, and stroke than their high income peers (SCDHS CHA).

***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:

From 2007-2010, 24.2% of women did not receive timely prenatal care, a rate that is unfavorable comapred to NYS and the US (21.9% and 17.3%). 7.7% of births were low-weight, below both the statewide (8.2%) and national (8.2%) proportions and close to the HP 2020 target (7.8%). There was an annual average of 4.2 infant deaths/1,000, better than both the NY and national rates (5.3 and 6.3 respectively) and less than the HP 2020 target of 6.0/1,000. However, the African American infant mortality rate was 10.06/1000, or more than twice the rate among whites.(bio-info@health.state.ny.us) There was an annual average of 16.1 births/1000 to girls age 15-19, below the NY and national rates (23.7 and 36.6 respectively). Hispanics had the highest teen birth rate followed by non-Hispanic Blacks. The teen birth rate among Hispanics was 48.7/1,000 vs. 6.2/1000 for Whites and 28.5/1000 for Blacks. Survey repondents perceived access to prenatal care as adequate; however 10.1% of Medicaid/uninsured residents had trouble obtaining care for their children in the past year. (xxxi) The birth defect rate (>273.7/10,000) places Suffolk in the highest group of NY counties. (xxxiv)

***Challenges 6:**

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

Based on the Prevention Agenda, 29.1% of adults and 17.5% of children/adolescents are obese, 14.4% of adults smoke; and 73.7% of adults received the recommended colorectal cancer screening. Such findings are favorable compared to NYS except for adult obesity. Based on self-reports, 74.9% of Medicaid members report are overweight vs. 66.3% of the privately insured and 69.9% of the uninsured.

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Among uninsured children or those covered by Medicaid, overweight levels were much higher (47.9%) than in children overall (17.1%). 44.6% of adults overall meet physical activity recommendations (unfavorable related to NYS and national rates), though only 35.9% of Medicaid/uninsured residents do. Among children, almost 60% have adequate physical activity. Overall, 7.4% of adults are chronic drinkers and 20.4% are binge drinkers. Rates of problem drinking are higher among the population overall than among Medicaid/uninsured persons, but drug abuse is higher in the latter populations. The annual average age-adjusted drug-induced mortality rate is 14.6 deaths/100,000, or well above statewide and national rates. Almost 60% of key informants felt that drug abuse was a major problem.

***Challenges 7:**

Any other challenges:

The importance of behavioral health problems that often coexist with physical illness cannot be overemphasized. About half of individuals in OMH licensed Suffolk County programs have at least one chronic medical condition, similar to data for Long Island and NY as a whole. There is inadequate provider capacity and case management in both behavioral health and primary care, making this problem particularly intractable. In addition, mental health programs (for those with a primary psychiatric diagnosis) often refuse to serve those who also have developmental disabilities. In general, there are few intermediate-level behavioral healthcare programs and a lack of screening for behavioral health conditions. Addressing the needs of this population across the continuum (including the social determinants of health) will be key to meaningful reform.

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**.

The most pressing gaps are: primary care shortages/inefficiencies; geographic misalignment of providers with needy populations; inadequate behavioral health resources; a lack of care coordination; and excess inpatient and nursing home capacity. Outpatient gaps are reflected in high PQIs, PPVs, and PPRs that would be alleviated with adequate access. Key informants cited behavioral healthcare as the most difficult to access, followed by substance abuse treatment, specialty care, and dental care. Few providers are trained in cultural competency/health literacy.
In regard to inpatient capacity, there are 3,099 certified inpatient beds and 210 newborn bassinets (July 2014) with highly variable occupancy rates. Chemical Dependency, Psychiatric and Transitional Care Unit beds are fully utilized at (or over) 85% occupancy. Chemical dependency beds (40) are consistently at 97.85% occupancy and additional beds are needed. However, certified beds in categories with consistently low occupancy rates (<85%) could be reduced. These include medical/surgical beds (78.51% occupancy), neonatal (68.57% occupancy), OB/GYN (58% occupancy), pediatric (43.74% occupancy), rehab (61.36% occupancy), and newborn bassinets (40.89% occupancy). There are two small sets of specialty beds (alcohol and burn) that have ten and six beds respectively. Because they are small, provide specialized care, and have highly variable occupancy rates, they should not be targeted for reduction. Suffolk has 42 nursing homes, located mostly in the western and central submarkets, with only seven (17%) in the east. They house a total of 8,561 beds. The mean occupancy rate is 91.37% and the median occupancy rate is 92.50% (based on 38 of the 40). Several have significantly lower occupancy rates of less than 68-76%. A reduction of 50 beds may be warranted. While the nursing homes generally provide a broad range of services, some services are missing, including: AIDS, behavioral intervention services, coma services, dementia programs, hospice, limited transfusion services, and pediatric. An addition of behavioral intervention services and dementia programs is warranted along with transfusion services to support the chronically ill. Hospice services are not offered in County nursing homes.

Behavioral health resources are unevenly distributed. Many providers do not accept insurance. There is a chronic shortage of prescribers (psychiatrists and psychiatric NPs). All age groups receive services at much lower levels than statewide: children < age 8 at 35% of the state average; children aged 9-17 at 50% of the state average; adults aged 18 to 64 at 60% of the statewide average; and adults age 65+,at a rate of 55% of the statewide average.(xxxv) All clinics report wait lists. The most profound problems are in children's services where the fiscal viability of programs is threatened due to inadequate Medicaid reimbursement. Many people are admitted to inpatient services because of inadequate ambulatory resources. Community-based resources for both mental illness and substance abuse need to be expanded along with partnerships between primary care, care managers, payers, and patients.

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***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.

The ratio of PCPs to population (84.9/100,000) is below the statewide average (109.6/100,000)(xxxvi) with shortages ranging from 7 FTE providers to almost 150 FTE per submarket.(xxxvii) Fewer than 50% of PCPs have PCMH models of any level.(xxxviii) In general, few outpatient providers (primary or specialty) have evening and weekend hours, leading the higher ED use. Public transportation is very limited. In a composite measure, 66.6% of Medicaid/uninsured report access problems vs. 43.8% in Suffolk overall vs. 39.9% nationally.(xxxix)

Providers are geographically misaligned with populations in need, being concentrated in the more prosperous population centers. For example, ancillary and specialty providers and rehabilitative services are concentrated in the Core, Southwest, and Northwest submarkets, leaving some areas with little to no ready access. There are no freestanding ambulatory surgical centers in the East, while both the Northwest and Southwest have two each; the East has no office based surgery practices, while the Core has 27. Access to behavioral healthcare is particularly constrained for Medicaid and uninsured populations. Providers cite low Medicaid reimbursements as a root cause. Waiting time for follow-up appointments after a hospitalization averages many weeks.(xl) MCOs typically don't cover intensive services for individuals such as residential treatment, thus further limiting access.

Care management (CM) exists, but is highly fragmented. There are several care management initiatives in Suffolk led by Health Homes and a variety of care management agencies and Medicaid MCO plans, but they tend to be understaffed and quality is variable. There is a lack of coordination and communication across the continuum. In addition, the scope of some efforts has been limited by regulations (e.g. Health Homes only focus on super-utilizers), lack of resources, lack of standardized performance metrics, and a lack of aligned incentives. In the inpatient setting, CM is mostly focused on Utilization Management (UM) and Discharge (D/C) planning, but surveys revealed few warm handoffs into the community. There is limited evidence of multi-disciplinary rounding in hospitals. Few processes are in place to setup follow-up appointments, to complete timely transmission of discharge summaries, and to ensure that medication reconciliation has occurred.(xli)

***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.

Primary Care will be expanded based on the FQHC model and a closer relationship with Hudson River Healthcare (HRH), which is taking over the operation of the County health clinics. We will expand the use of nurse practitioners (NPs), including NP-led clinics (Level 3 PCMH certified) that operate from retail stores. We will provide assistance to PCPs to encourage the adoption of advanced practice models and use staff at the top of their licenses. To reduce health disparities, we will assure that new models (across all services and projects) address issues of cultural competency and heath literacy. To address reimbursement barriers, we will partner with MCOs to ensure the financial feasibility of new and existing models. We intend to integrate more closely with Health Homes, all three of which are partners in the Suffolk PPS. Our bioinformatics teams will build analytical models that target complex patients and map patient clinical characteristics to utilization levels and payments that support resource-intensive targeting and care management.

To address geographic misalignment, we will make greater use of HIT/telemedicine. This may include remote consultations with specialists (mental health and perinatal) along with improved information exchange. This will allow PCPs and other providers to organize and disseminate information in real time, thus improving care coordination, increasing quality, and lowering costs. DSRIP partnerships will enable PPS members to take a population health approach in deploying providers to address maldistribution. We will leverage Community-based Organizations (CBOs) to provide support services such as care transitions, chronic disease management, medication management, nutrition support, transportation, home and family assessments, health benefits counseling, and care giver support. To build greater cultural competency (CC)/health literacy (HL), we will institute training programs related to CC/HL principles and work with educational institutions to build a diverse workforce. To right-size the system, we will address the excess inpatient/nursing home capacity through collaborative discussions with partners centered on a data-based approach, use of external facilitators, and the creation of financial incentives to transfer inpatient capacity to outpatient and complementary services over the 5 year DSRIP period.

Section 3.7 - Stakeholder & Community Engagement:

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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).

The design of the primary research assured broad stakeholder/community engagement. The patient survey itself (900 responses total) included a diverse patient group both geographically and socioeconomically. Our large partner groups (Hudson River Healthcare, Suffolk County DHS, major hospital systems, and behavioral health providers) provided the lists of patients from which the final respondents were drawn. We solicited input from our entire PPS membership in developing the list of 250 Key Informants so that responses would represent the community in a balanced way. PAC meetings were held monthly starting in mid-August, and at the first one we explained the goals and objectives of the CNA as well as the process. Early on, we developed a website that kept all our members and the public informed as to our PPS development. As sections of the CNA were completed, we posted them on the PPS website and invited feedback. The PAC meeting in mid-Sept. was devoted to presentation of the results of the CNA (both the primary research and the secondary analysis) and the relationship to the project choices. PAC members were asked to provide additional input related to community needs and to provide feedback in writing regarding the extent to which they perceived strong alignment between the identified needs and the project selections. Several of the project concepts were refined based on PAC member feedback. A second PPS member survey of community needs and partner capabilities was conducted by xG Health (our consultant) involving both interviews and questionnaires of hospitals, PCPs, clinics, and care managers. This helped to identify key issues related to delivery system redesign. In November, a meeting was held with community leaders (churches, advocacy groups for ethnic/racial minorities, other community and social service, safety net leaders) specifically to address issues of cultural competency (CC) and health literacy (HL). It was well attended and provided key input for weaving CC/HL concepts into all projects as cross-cutting themes. To continue to keep all PPS members and the broader community involved and informed, we send out two separate weekly newsletters to almost 500 recipients to encourage them to stay involved. Going forward, our governance structure provides for a Community Needs Subcommittee so that the CNA can be a living and evolving document.

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

Key informant surveys were used rather than focus groups for their greater reach and methodological rigor. Individuals with a broad interest in the health of the community completed online surveys. Participants were drawn from lists provided by key partner organizations across the continuum, including physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, particularly Medicaid members and the uninsured, as well as of the community overall. Key Informants were first contacted by letter to request their participation; follow-up emails were then sent with a link to take a survey online. Final participation included 118 respondents, including 11 physicians, 15 public health professionals, 59 other health providers, 24 social service providers and other community/business leaders. Key Informants were asked to rate the severity of various health issues. Follow-up questions asked them to describe why they identify problem areas as such, and how these might be better addressed.

***Community 3:**
Summarize the key findings, insights, and conclusions that were identified through the stakeholder and community engagement process.

Community/stakeholder feedback was integral to the identification of priority areas. From this process, we learned of widespread access problems and of the misalignment of resources with vulnerable populations. We heard first hand of the special needs of certain populations, such as undocumented residents and ethnic/racial minorities, who often lack transportation to sites of care and distrust the system, and who lack affordable child care and housing. Key Informants ranked the most pressing issues as: mental health; access to housing; substance abuse; nutrition, physical activity/ weight; tobacco use; and access to healthcare services. We refined our understanding of the dysfunction within the health services delivery system itself, finding that access problems are paramount and that the delivery of health services needs to be rationalized and coordinated in a way that will encourage appropriate use of services and patient engagement while reducing health disparities. Along with adding/redeploying resources in the outpatient and community settings, we gained greater insight into the social determinants of health that must be recognized and addressed for specific populations.

In the chart below, please complete the following stakeholder & community engagement exhibit. Please list the organizations

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engaged in the development of the PPS strategy, a brief description of each organization, and why each organization is important to the PPS strategy.

[Stony Brook University Hospital] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
1	Hudson River Healthcare (HRH)	Operates County Clinics and FQHCs; Major provider of primary care to Medicaid and uninsured. HRH also operates one of the three County Health Homes.	Expanding primary care is essentialm to the PPS strategy. HRH input was key to understanding the specific needs of DSRIP target populations and designing responsive strategies.
2	Health and Welfare Council of Long Island (HWCLI)	HWCLI serves the interests of poor and vulnerable people on Long Island by convening, representing, and supporting the organizations that serve them; and through Illuminating the issues that critically impact them Organizing community and regional responses to their needs Advocacy, research, and policy analysis Providing services, information and education.	As an umbrella organization for other CBO's, HWCLI has detailed knowledge of community needs and many valuable community connections. Provides an opportunity to directly engage the uninsured.
3	Nesconset Center for Nursing and Rehabilitation	A 240 bed facility with a large subacute Rehab division	Leaders of this facility have been particularly active in articulating the needs of the senior population and in proposing innovative solutions for this segment of Medicaid recipients.
4	North Shore/LIJ Health System (NSLIJ)	Major regional healthcare system. NSLIJ also operates one of the three County Health Homes.	With facilities across the care continuum, NSLIJ brings a broad-based perpective to and delivers substantial resources to this endeavor.
5	Suffolk County Maternal Infant Community Health Collaborative	A division of the Suffolk County Department of Health Services	Improving maternal/infant health is fundamental to health throughout the lifespan.
6	Suffolk County Dept. on Aging	A division of the Suffolk County Department of Health Services	Lowering preventable admissions is part of the strategy and this organization will be instrumental in developing programs to keep seniors healthy.
7	Association of Mental Health and Wellness	Provides a range of social and behavioral health services	Addressing behavioral health services and the social determinants of health is essential to the PPS strategy.
8	Economic Opportunity Council of Suffolk County	Provides a range of social and financial services to the needy.	A key partner in helping to address the social determinants of health. Provides many sorts of financial assistance.
9	Planned Parenthood	Planned Parenthood provides reproductive and sexual health care at 11 health centers in Suffolk, Westchester, Rockland, and Putnam counties. The organization helps people get the services and information they need to prevent unintended pregnancies and sexually transmitted diseases while staying healthy.	Provides direct services, education, and advocacy to DSRIP priority populations.
10	Family Service League	A grass roots social service agency.	FSL provides both physical and emotional aid to Long Island's most vulnerable citizens. FSL gives seniors companionship and purpose;

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[Stony Brook University Hospital] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			provides services for the homeless; addresses the needs of young adults with addiction or mental illness; and offers food and shelter to the working poor facing heavy financial burdens. Servcies are integrated within a single locations.
11	F.R.E.E.	Behavioral health provider	F.R.E.E. has been a key partner in the behaviroal health strategy for this PPS.

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

[Stony Brook University Hospital] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
1	Need for Delivery System Integration Across the Care Continuum	Suffolk County has many assets and resources, but there is general fragmentation and misalignment of resources and needs. There is excess inpatient capacity, but shortages in outpatient and community-based resources. In particular, there is a severe shortage of primary care and behavioral health providers. Resources are often not located in close proximity to Medicaid/uninsured hotspots. The care coordination infrastructure lacks standardization, there is minimal health information connectivity, and providers are not using staff at the top of their licenses. No hospital in the County has a robust transitional care program with a full package of 30-day transition interventions. Few primary care practices have Patient Centered Medical Home (PCMH) designation and the ratio of primary care providers/population falls well below national averages. Measures of avoidable utilization (PQI, PPV, and PPR) are high.	Suffolk PPS Primary Data Collection Potentially Preventable Readmissions NYSDOH (2014, June). Prevention Quality indicators (PQI/PDI) – Composites of all Measures NYSDOH (2014, June). NYSDOH. Medicaid Potentially Preventable Emergency Visit (PPV) 2012
2	Need to provide a 30 day supported transition period to reduce 30 day	Suffolk County compares unfavorably to NYS related to mortality rates for kidney disease and	Suffolk PPS Primary Data Collection

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[Stony Brook University Hospital] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
	readmissions for chronic health conditions	respiratory disease. There are disparities among Medicaid/uninsured populations related to diabetes and many chronic disease risk factors. No hospital in the County has a comprehensive transitional care program	Potentially Preventable Readmissions NYSDOH (2014, June). Prevention Quality indicators (PQI/PDI) – Composites of all Measures NYSDOH (2014, June). NYSDOH. Medicaid Potentially Preventable Emergency Visit (PPV) 2012
3	Need to avoid unnecessary transfers of SNF patients to acute care facilities	Few SNFs participate in Health Information Exchanges (HIE) and many do not use INTERACT or INTERACT-like tools to prevent transfers. . Among dual eligible beneficiaries in SNFs, 40% of hospitalizations are unnecessary and 23.5% of people admitted to a post-acute care SNF were re-hospitalized within 30 days.	Suffolk PPS Primary Data Collection Potentially Preventable Readmissions NYSDOH (2014, June). Prevention Quality indicators (PQI/PDI) – Composites of all Measures NYSDOH (2014, June). NYSDOH. Medicaid Potentially Preventable Emergency Visit (PPV) 2012
4	Need for observational programs in hospitals	There is a high level of short stay (length of stay less than 2 days) admissions in Suffolk County -- 27% of Medicaid admissions (9,475) were short stay. This population might have been served by an observation status if the capacity were available. Along with PQI conditions, behavioral health conditions are top drivers of short hospital stays. No community providers are currently receiving information about these patients and none have a mechanism to directly admit patients to the observation units. Many of these admissions are the result of insufficient outpatient chronic care and care coordination.	Short Stay Admissions Inpatient volume estimated from SPARCS 2012 LDS for Medicaid members served in a Suffolk facility; Chronic disease prevalence from the Chronic Disease Data for 2012 Medicaid Population; Population size data from NYSDOH Suffolk PPS Primary Data Collection Provider Capability
5	Need to engage, educate and integrate uninsured and low/non utilizing Medicaid members.	Uninsured populations have very limited access to care. Many use the ED as their only source of care.	Suffolk PPS Primary Data Collection PRC Population and Key Informant Surveys Uninsured ED visits New York State

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[Stony Brook University Hospital] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
			Department of Health [DOH]. (2014, April). Outpatient Visits (SPARCS Limited Data Set): 2012.
6	Need for greater integration of primary care behavioral health services	Behavioral health care is largely inaccessible. Many patients have coexisting behavioral and physical health conditions. Key Informant rate behavioral health as the service with the greatest access barriers.	Suffolk PPS Primary Data Collection NYS OMH Patient Characteristics Survey Diabetes Monitoring for People with diabetes and Schizophrenia – HEDIS Initiation of Alcohol and Other Drug Dependence Treatment – HEDIS Follow-up after Hospitalization for Mental Illness within 30 days - HEDIS
7	Need for the evidence-based disease management strategies in adults with or at CV disease.	Heart disease is the leading cause of death in the County. Disparities exist in Medicaid and uninsured populations vs. population overall. Quality measures fall below statewide baselines in many cases. Health Disparities - Unfavorable rates relative in the Medicaid/uninsured vs. the overall population relative to: •Taking action to control high blood pressure •Cardiovascular risk factors •Smoking	PRC Population/ Key Informant Surveys PQI 13 (Angina without Procedure) 2013 QARR Report - Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia; Aspirin Use; Advising Smokers to Quit, Discussing Smoking Cessation Medications; Flu Shots for Adults
8	Need for the evidence-based disease management in medical practice for adults with/at for diabetes	The diabetes rate is higher in Suffolk (11%) than statewide (9.7%). Health Disparities - Among the Medicaid members and the uninsured, the rate is 15.7%. Managing diabetes will control avoidable hospitalizations and preventable ED visits. The overall prevalence of diabetes led us to prioritize this over HIV/AIDS, renal disease, and palliative care. Renal disease and palliative care are included as components of other projects (2.b.iv, and 2.b.vii)	PRC Population and Key Informant Surveys NYSDOH - PQIs - Diabetes Long-term Complications, Short Term Complications, Uncontrolled diabetes, Adult Composite Diabetes Monitoring for People with diabetes and Schizophrenia – HEDIS (unfavorable) Comprehensive diabetes Care – HBA1c Testing – HEDIS
9	Need for improved self- management skills	Asthma is highly prevalent and the cause of many	PRC Population and Key

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[Stony Brook University Hospital] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
	in adults and children with asthma	unnecessary hospitalizations and ED visits. Better self-management could lead to reductions in unnecessary utilization. Health Disparities - In the Medicaid/uninsured population, 11.9% of children currently have asthma, which is more than twice the countywide prevalence	Informant Surveys Prevention Quality indicators (PQI/PDI) Composites of all Measures; Individual PQIs PQIs_5 and 15 (Adult Asthma composite); PDI_14 (Pediatric Asthma) NYSDOH. (2014, June). Medicaid Inpatient PQI for Adult Discharges by Patient County: Beginning 2011.
10	Need to prevent substance abuse and other mental, emotional behavioral disorders.	Substance abuse and other mental, emotional behavioral disorders are highly prevalent. Suffolk County rates exceed statewide rates on the following Prevention Agenda measures: -Age-adjusted percentage of adults with poor mental health for 14 or more days in the last month (13.8 vs. 11.8) Health Disparities – Among the Medicaid/uninsured population, rates of unfavorable mental health findings are almost twice that of County residents overall. Substance abuse rates are also higher.	New York State Prevention Agenda Suffolk PPS Primary Data Collection - PRC Population and Key Informant Surveys
11	Need to improve population-based health chronic disease prevention and management.	Chronic disease is highly prevalent. Prevention strategies are needed to address excess cancer rates as well as obesity and smoking. Suffolk County rates exceed statewide rates on the following measures: - Percentage of adults who are obese (29.1% vs. 27%) - Asthma emergency department visit rate per 10,000 (54.1 vs. 50.8) - Asthma emergency department visit rate per 10,000 - Aged 0-4 years (134.4 vs. 117.2) - Age-adjusted heart attack hospitalization rate per 10,000 (18.6 vs. 16.1) Health Disparities – Racial disparities exist in relation to cancer rates and outcomes.	New York State Prevention Agenda Suffolk PPS Primary Data Collection - PRC Population and Key Informant Surveys

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
16_SEC038_FINAL CNA.docx	12/18/2014 02:20:28 PM	Community Needs Assessment

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

DSRIP PPS Organizational Application

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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: **Stony Brook_Section4_Text_Final DSRIP Project Plan Application _ 12 19 2014.docx**

Description of File

Project Plan application

File Uploaded By: lucykenn

File Uploaded On: 12/22/2014 11:46 AM

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

Currently Uploaded File: **Stony Brook_Section4_ScopeAndScale_Stony Brook scale_and_speed.xlsx**

Description of File

File Uploaded By: lucykenn

File Uploaded On: 12/22/2014 12:05 PM

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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.

Implementation of the projects will have an impact on the many 40,000 employees in our PPS in terms of changes in workflow and approach to communication within and outside our partner organizations, requiring training. There will also be new roles, departments and organizations created across our partner organizations to support the emerging integrated delivery system. We estimate the need for an additional 847 positions over 240 partner organizations; however, less than half of these positions (~366 positions) would be "net new" as many of our partners currently report excess capacity and significant turnover rates that can permit the filling of a position that supports the DSRIP projects. To a lesser extent, redeployment will also reduce the "net new" positions. As a result of the targeted 25% reduction in avoidable hospitalizations and ED visits, we estimate a reduction of 150 FTEs that will be satisfied primarily through attrition, as the

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turnover rates at the PPS partners average 12% per year (per community needs assessment).

With input from union representatives, HR leadership, and administrative leadership across our PPS, we have created a comprehensive workforce strategy that seeks to balance the supply and demand for staff with an emphasis on making, in a sustainable way, more care available in the community where it is need, provided by staff working at the top of their licensure. We will deploy three approaches to ensure that people with the appropriate skill sets are available to support the projects as dictated by their implementation plans:
1. Hiring consultants for short-term, immediate needs.
2. Retraining and redeploying existing workforce particularly where there is excess capacity, as well as recruiting new staff with appropriate training. For difficult to fill positions, we will consider signing bonuses, tuition reimbursement, mentoring and mid-year evaluations for promotion and bonuses.
3.Leveraging attrition to meet workforce adjustments needs in that as positions turnover, they will be replaced with positions needed to support the DSRIP projects.
N=New, RD=Redeploy, RT=Retrain

MD, DO and Primary Care - N
Case Managers – RD, RT, N
Social Worker- RD, RT, N
Community Health Assistant – RD, RT, N
Nurse Health Manager – RD, RT, N
Supervisors/Managers – RD, RT, N
Population Health Mgmt (Coordinator, Analyst, Modeler) – N
Interface Developer – N
Project Manager – RT, N
IT Trainer/Specialist - N
Administrative Support Services – RT, N
Housekeepers – RD, RT, N
Nurse Practitioners – RD, RT, N
LPN's– RD, RT, N
CA's / NA's – RD, RT, N
RN's– RD, RT, N
Training Coordinators - N
Trainers – RT, N
Educators – RT, N
Allied Health Professionals (Recreational Therapist, Radiology Tech) – RD, RT, N
Behavioral Health Specialists (psychologists, psychiatrists, NPs) – RD, N
Mental health therapy aide - N
Physician Specialists (hospitalists, pulmonologist, etc) - N
Pt. Engagement Specialist and Communications – RT, N
Outreach / Community Health Worker- RT, N
Pharmacist - N
Statistician - N
Community Liaison – RD, RT, N
Health Coach/Addictions Counselor – RD, RT, N
Registered Dietitians –RT, N
Union/Non-Union – RD, RT, N

Key drivers of DSRIP's workforce impact in Suffolk County are: 1. The transition of care from inpatient to outpatient settings coupled with, 2. An expansion of primary care, behavioral health, case/care management and patient engagement services supported by the expansion of data analytics to identify patient needs early, and effectively coordinate the right care for the patient at the right cost, location and time. We project a need for fewer inpatient positions, exceeded by a need for additional outpatient positions, and anticipate minimal negative

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impact to the workforce as the contraction on the part of inpatient providers within the PPS will be minimal, and largely addressed through attrition.

***Strategy 2:**

In the response, please include

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

To minimize the effects of redeployment and retraining, our PPS will engage a workforce consultant to engage the PPS members, update and verify the data used to make workforce redeployment and retraining, and recruitment decisions and create a sophisticated communication / engagement plan that supports clear, real-time, transparent communication to the relevant employees, union leaders, and PPS partners. Redeployments will be minimized by primarily relying on attrition to make needed positions available to support the DSRIP projects. When contemplated, redeployment will be done per the workforce plan developed with union and partner HR leadership; keeping employees whole, when possible, working within the same organization and bargaining unit, receiving at least 95% of their current compensation, minimizing separations. When presented with a redeployment opportunity, employees will get a documented comparison of current versus new job responsibilities given existing collective bargaining agreements and NYS civil service law framework.

Roughly 40% of the PPS' workforce will need some level of retraining. Much will be on systems, IT, process redesign, health literacy and cultural competency. Training activities will occur during normal business hours to minimize negative impacts. Multiple training approaches will be utilized to ensure that the learning objectives are achieved in the manner that least interferes with the employee carrying out their regular duties.

Our PPS will establish a central position control for new positions. New opportunities will be posted in a central location. For difficult to recruit positions, we will evaluate the use of incentives such as tuition forgiveness, signing bonuses, mentoring.

A survey of our PPS partners indicates that the greatest workforce shortages are in behavioral health practitioners (MDs, psychologists, NPs, social work) and nurses (RNs), followed by primary care practitioners and social workers. These shortages will pose challenges to implementing all 11 DSRIP projects, particularly as these positions are essential providers of care within DSRIP (behavioral health and primary care), or connected with the enhanced provision of care management (RN and social work). Care managers are important as there will be a need for additional coaching and advising family caregivers, helping families evaluate residential housing or home care options, assisting with management of doctors' appointments and medications, providing support with legal and financial matters and assessing the safety and well-being of the client and family. Without an increase in new positions within BH, primary care, RNs and social workers, our PPS will lack the necessary FTEs to expand the provision of adequate care management, BH or primary care services to the roughly 220k Medicaid beneficiaries and 160k uninsured within Suffolk County targeted by our 11 projects.

***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	.4%
Retrain	40%
New Hire	1%

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.

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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.

Each of the 11 project development teams did initial work identifying their project's retraining needs; however, a workforce consultant will be engaged in the implementation planning phase to conduct a training needs assessment, refining and validating the projections. The specific extent and type of retraining needs will be assessed, driven by the actual workforce shifts, technical training, health literacy, cultural competency and process changes. The needs assessment will be developed with input from our PPS partners and union representatives, and it will outline who needs retraining. Our partners and union representatives will also have input into the training curricula.

The PPS defines retraining as the process of learning a new skill or trade in response to a change in profession rather than an "upward" movement in the same field. Staff that may be taking on a new role in the PPS and member organizations, such as a management role, require supervisory, leadership, management, communication, delegation, planning etc. training and development. Staff that will require a new skill set, including license or certification, will need training and education through on-the-job training, formal education, job shadowing, and/or trial deployment. Staff may need training on new processes, cultural competency, and health literacy.

The PPS workforce strategy is to utilize existing county, state and federal programs; the internet, online and hybrid adult learning methods along with communication methods to retrain identified employees. Resources that have been identified include: The NYS Primary Care Service Corps; The Health Workforce Retraining Initiative; Doctors Across NY, Empire Clinical Research Investigation Program, training funds available to union locals; professional development and continuing education programs at local and online colleges and universities.

We will blend on-the-job, web based, hybrid, trainer-led instruction (in person or web based), as well as leveraging existing training programs offered by PPS members, unions and training staff presently employed by the PPS' partners. In addition, SBU's allied health schools (Medicine, Nursing, Dental, Social Work, and Health Technology) can provide necessary training. Our partners such as NSLIJ also have a substantial corporate training center that will support the PPS' training needs.
The PPS members in total employ about 40,000 employees. Approximately 16,000 employee will need some level of training or retraining. The majority of DSRIP (re)training activities will focus on the introduction of new processes, procedures, protocols, equipment, IT systems, cultural competency, health literacy, etc. to support the integrated delivery system our PPS is creating. As we are transforming the way care is provided altering workflow (processes, handoffs) and communications approaches (IT, cultural competency, etc), this training will largely be involuntary.

The smaller subset of voluntary training activities is training associated with voluntary career development, or training/education associated with redeployment where the staff requires a significant change in qualifications, education, licensing, certification, or a new role entirely. This staff member may be one with a narrow, highly specialized skill set where no redeployment is possible without significant training/education and the alternative is separation, or a PPS staff member that elects to take classes or training in order to obtain a vacancy, mostly in non-acute care settings, that requires significant increase in skill, knowledge, education, license or certification.

Many PPS members have public sector and/or unionized segmentsegments of their workforce which adds complexity to the retraining and requires further analysis in collaboration with the unions, management, and our workforce consultant.

***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 PPS expects minimal impact to the wages and benefits of existing employees to the extent that staff remains with their current employer. PPS staff members that voluntarily move to another employer within the PPS may experience a change. The PPS will take action to minimize the potential negative impact of retraining activities to current wages and benefits of existing employees by engaging a workforce consultant to lead the PPS in: 1. Identifying the potential negative impacts to wages and benefits posed by PPS training plan and then 2. Developing a plan and a process for minimizing such impacts. This plan will be concentrated on the PPS members with the

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greatest number of affected employees, which will likely be the hospitals and skilled nursing facilities. The plan will be developed with input from employers, HR and union representatives.

***Retraining 3:**

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

The total number of PPS member staff that is expected to receive some training is significant. Much of this training will be involuntary (around process improvement, communication, and cultural competency and health literacy). Voluntary retraining activities will be minimal. The PPS will utilize available support mechanisms such as unions, Employee Assistance Programs, and supervisors to engage the employee in an effective dialog about the need for retraining. The goal is to minimize the number of staff that refuse retraining by conducting training during normal business hours and utilizing training methods minimizing the negative impacts to workload, scheduling, etc.

***Retraining 4:**

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

Our PPS will be working with labor representatives as partners to understand the collective bargaining agreement requirements and navigate the unique rights and obligations afforded therein related to retraining, redeployment, layoff or separation. Union leadership from a minimum of five locals have been participating members of the Suffolk DSRIP PAC. The unions also have participated in providing feedback during the Workforce Application Task Force meeting. Ongoing labor representative participation in the PAC is recognized as essential as is their input into the workforce plan.

***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	98%
Partial Placement	1%

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.

Our workforce plan goal is identify the numbers and types of positions needed over the five-year implementation period to cost-effectively support our 11 DSRIP projects; having the right people with the necessary skill set working at the top of their licensure, in right place and time, at the right cost. Redeployment is a fast, cost effective method of filling needed positions. Our PPS will engage a workforce consultant: to review the supply versus the demand for positions across the PPS' partner organizations; ensure current, relevant data is used in the planning process, and that staff and union representatives are effectively engaged. We will have a five-year strategy to deliver workforce changes (enhance productivity, waste reduction, adoption of new tech and process, sustainability).

The PPS' workforce consultant will project and verify the numbers and types of positions by department across the PPS that are subject to redeployment. The PPS has initially identified approx. 150 FTE at-risk positions and a total need for 847 total positions (including 366 new positions) in order to support the 11 DSRIP projects.

During DY1 impacted managers with excess staff will work with the workforce consultant to develop plans to meet their targets by developing lists of individuals that may be displaced with the shift of emphasis from inpatient to outpatient care. Managers will also assess the prior performance of these individuals as this may impact their ability to be redeployed. The PPS will utilize available support mechanisms such as unions, Employee Assistance Programs, and supervisors to engage the employee in an effective dialog about the

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need for change and the position options available. When redeployment is necessary, the goal is to make every effort to find the employee a position within the PPS that keeps them whole.

Redeployment is defined as transferring staff within or to other organizations that may typically require hiring to fill positions. Redeployment may be one or any combination of movement to a different facility, department, and role or job classification. Staff remaining in their current role within the same department will not be considered 'redeployed'. Redeployment is voluntary, however the individual will understand that remaining in their current role may not be an option.

***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.

The PPS expects minimal impact to the wages and benefits of existing employees to the extent that staff remains with their current employer. PPS staff members that voluntarily move to another employer within the PPS may experience a change. The PPS will take action to minimize the potential negative impact of retraining activities to current wages and benefits of existing employees by engaging a workforce consultant to lead the PPS in: 1. Identifying the potential negative impacts to wages and benefits posed by PPS redeployment plan and then 2. Developing a plan and a process for minimizing such impacts. This plan will be concentrated on the PPS members with the greatest number of affected employees, which will likely be the hospitals and skilled nursing facilities. The plan will be developed with input from employers, HR and union representatives.

***Redeployment 3:**

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

Redployment will be voluntary, but staying in an employees current position may not be an option. The Suffolk PPS plans to minimize the need for redeployment by relying on attrition, however in cases where redeployment is refused by the employee, the employee will enter a redeployment pool. Every effort will be made to find a position for the employee within the Suffolk PPS. The PPS will utilize available support mechanisms such as unions, Employee Assistance Programs, and supervisors to engage the employee in an effective dialog about the need for change and the position options available. The goal is to retain and retrain every PPS staff member that wants a position.

***Redeployment 4:**

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

Our PPS will be working with labor representatives as partners to understand the collective bargaining agreement requirements and navigate the unique rights and obligations afforded therein related to retraining, redeployment, layoff or separation. Union leadership from a minimum of five locals have been participating members of the Suffolk DSRIP PAC. The unions also have participated in providing feedback during the Workforce Application Task Force meeting. Ongoing labor representative participation in the PAC is recognized as essential.

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.

Our DSRIP projects will create new employment opportunities. While the exact numbers of new hires will be refined as we implement our projects, our PPS identified the need to hire approximately 366 staff (the "net new" portion of our total 847 positions, the remainder being filled through excess capacity, retraining and, to a lesser degree, redeployment and turnover). It is important to note that this is a preliminary estimate and that the exact workforce implications of DSRIP might fluctuate from this estimate as the projects progress. The current estimates for new hires include:

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MD, DO and Primary Care – to expand primary care services for patients in the community (~25 hires)
Case Managers – to support patients in navigating services relative to their needs (~19)
Care Managers for uninsured project – To support uninsured patients in project 2.d.i (~5)
Social Worker- to increase assistance to patients and their families (~12)
Community Health Assistant – to support patients in successfully navigating services (~9)
Nurse Health Manager – to coordinate care navigator services (~5)
Supervisors/Managers – to provide management and leadership to PPS projects and initiatives(~18)
Population Health Mgmt Coordinator –to manage and monitor the integrated delivery system(~2)
Population Health Mgmt Analyst & Modeling – to provide data analysis, collection and reporting to aide in monitoring of the integrated delivery system(~4)
Interface Developer – to enhance IT interconnectivity between PPS partners(~2)
Project Manager – to manage IT implementation (~1)
IT Trainer/Specialist – to train PPS members on new IT technologies(~4)
Administrative Services (helpdesk, etc.) – to provide administrative support to the PPS projects and initiatives (~19)
Housekeepers – to support the expansion of outpatient clinical activities(~3)
NPs/RN's – to staff clinics, and post-acute care settings (~34)
LPNs, CAs, NAs– to assist in the expansion of primary care access(~20)
Training Coordinators / Trainers – to supervise and support patient and staff training activities(~7)
Educators – to support patient educational needs within the 11 selected projects(~18)
Allied Health Professionals (Recreational Therapist, Radiology Tech, MHTA) – to provide needed outpatient allied health services (~12)
Physician Specialists (hospitalists, pulmonologist, etc) – to provide expanded access to specialist care(~20)
Pt. Engagement Specialist and Communications – to engagement the targeted patients (~5)
Outreach Worker / Community Health Worker- to provide assistance to patients in their homes (~59)
Pharmacist – to support medication reconciliation and adherence program for the IDS (~1)
Health Coach/Addictions Counselor – to actively engage patients in their care (~12)
Registered Dietitians / Nutritionists –to provide guidance and engagement on eating healthy (~5)
Behavioral Health Specialists (psychologists, MD psychiatrists, NPs) – to expand behavioral health services to patients in the community (~44)
Other Non-Clinical (Statistician, Community Liaison) –(~1)
Union/Non-Union – the mix of union and non-union employees is not anticipated to change significantly

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	39
Physician	45
Mental Health Providers Case Managers	87
Social Workers	12
IT Staff	11
Nurse Practitioners	37
Other	135

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.

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Funding Type	DY1 Spend($)	DY2 Spend($)	DY3 Spend($)	DY4 Spend($)	DY5 Spend($)	Total Spend($)
Retraining	4,000,000	4,000,000	3,500,000	2,500,000	2,000,000	16,000,000
Redeployment	240,000	525,000	132,000	20,000	15,000	932,000
Recruiting	965,000	1,218,750	1,447,500	1,593,000	25,000	5,249,250
Other	200,000	150,000	150,000	150,000	150,000	800,000

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 PPS serves the geographic area of Suffolk County. There are several state and federal programs that provide assistance with training, education and retraining for health care workers. The PPS and our workforce consultant will be evaluating the current utilization of resources (Doctor's Across NY, Physician Loan Repayment, Area Health Education Centers, Diversity in Medicine, Primary care Service Corp. and Health Workforce Retraining Initiative), expanding utilization where advantageous, evaluating existing structures within PPS members to leverage grant writing, grants management, collaboration of PPS members to leverage existing and new partnerships between education and industry, and STEM program enhancement for long term skill need in healthcare.

Our Workforce Committee will monitor and respond to RFPs for workforce retraining funds deemed appropriate to support our PPS' needs. This group will identify potential funding opportunities and prepare and submit any necessary application materials. We have identified the need to train 40,000 staff on process and communications changes, cultural competency/health literacy; recruit 366 new staff and retrain another 331 staff (a small portion of which may be redeployed).

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.

A Workforce Application Taskforce was formed consisting of seven union leaders from five unions representing a significant majority of the PPS member's workforce; and management leadership representing partners throughout the continuum of care including hospitals, skilled nursing facilities, behavioral health organizations, and ambulatory locations to create a set of workforce guiding principles and being identifying a workforce strategy for the PPS. In addition there was considerable conversation with the project teams and two workforce surveys conducted across the PPS. The Workforce Committee of the Executive Board will continue to engage stakeholders by use of surveys, meetings, sub-committees and PAC meetings.

***Engagement 2:**

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

The Suffolk PPS involved and included the local union leaders from Civil Service Employee Association (CSEA); Public Employee Federation (PEF); United University Professions (UUP); 1199 SEIU and New York State Nurses Association (NYSNA). We formally met as a group and discussed retraining, redeployment, and some specific questions around PPS initiatives, collective bargaining agreements, member policies and New York State Civil Service law.

***Engagement 3:**

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

Employee engagement is a key business driver for our PPS's organizational success. High levels of engagement will promote retention of talent, foster loyalty and improve organizational performance and stakeholder value.

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We have and will continue to implement a number of solutions to communicate important updates to the workforce of our PPS; we currently utilize a portal accessed via a link on our PPS website, expansion of this tool is planned as well as weekly email-based communications ('Week in DSRIP'). Other successful methods used in past by PPS members include: newsletters, social media, online surveys and polls, discussion groups and one on one interviews, posters and photos for bulletin boards and local flat screens, teleconferences and podcast stations to hear about news from around the PPS.

***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 PPS will continue to execute its communications plan, engaging partners and other stakeholders through two-way communications vehicles: surveys, meetings, webinars, sub-committees, email communications ('Week in DSRIP'), PAC meetings and other media. Our PPS is committed to communications with frontline workers around their importance relative to the DSRIP projects and will expand targeted communications to this group.

Our workforce consultant will collaborate with the PPS' workforce committee to identify structural barriers and methods for overcoming these barriers. Our PPS' position control committee will play a central role in address such barriers through regular review and resolution of staff issues including the inability/unwillingness to retrain/redeploy due to language barriers, educational requirements, shift and schedule changes, etc.

Section 5.8 - Domain 1 Workforce Process Measures:

Description:

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

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

☑ Please click here to acknowledge the milestones information above.

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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.

The "IPA" as the data steward will enter into Business Associate Agreements with each of the PPS partners. The "IPA" will retain a subcontractor to facilitate data collaboration and coordination activities among the PPS partners and to ensure compliance with federal and state health information privacy and confidentiality laws; including but not limited to, 45 CFR Parts 160 & 164, 45 CFR Part 46, NYS PHL Article 27-F, NYS MHL 33.13 and Office of Human Research Protection (OHRP) guidance. The "IPA" will enter into an agreement with a subcontractor to provide a secure environment for data storage, to ensure the confidentiality, integrity and availability of the data and to facilitate appropriate access.

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

Access to identifiable data will be limited to PPS providers and other authorized individuals responsible for clinical care, administration DSRIP project and quality of care oversight through role-based access. De-identified and aggregate data will be available to appropriate members of the PPS as required to meet the objectives of the DSRIP project(s). For members requesting access to data an application and signed PPS Confidentiality Agreement is submitted to the IT Governance for approval. The PPS partners will sign three (3) agreements 1) PPS Participant Agreement identifies the terms of the partnership and defines the policies and procedures related to data sharing; 2) PPS Business Associate Agreement; 3) PPS Data Use Agreements to further define the restrictions and requirements for data use, disclosure and protection.

***Confidentiality 3:**
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.

The PPS will leverage two different technologies to provide access to relevant patient information to the appropriate individuals noted above. When data is needed by a PPS provider for patient care the provider will utilize the State RHIO for access to real-time clinical data. The established processes available through the RHIO including but not limited to patient consent, role-based access, integration

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with EMR's and patient locator service all ensure that confidentiality is maintained and access to the correct patient information by medical, behavioral and psychosocial healthcare providers is achieved. The PPS will ensure the PPS provider is signed up to the RHIO and adequately trained to exchange real-time patient information. When data is needed for care management the PPS partners will utilize the Care Management IT platform which leverages the same consent and role-based access processes as the RHIO to ensure compliance with federal and state regulations. Additionally, the Care Management IT platform is compliant with the CMS Data Use Agreement requirements to house Medicare Shared Savings Program data for its clients that are participating in ACO's. For PPS providers and other authorized individuals as noted above that do not have full EMR capabilities we will use the DIRECT product. Direct is a compliant web-based exchange which facilitates access to real-time patient information in the absence of an EMR.

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 organizational units responsible for reporting results and recommending actions are the PPS Informatics Unit and the PPS Executive Unit. The Executive Unit is the population health administrative department that will oversee project implementation, management and evaluation. The PPS Informatics Unit is responsible for data collection, synthesis and interpretation, while the Executive Unit will focus on action as a result of that analysis. Both units will have active participation from clinicians and informaticists and will also work closely with and report to the PPS IT, Clinical and Financial Governance Bodies (subcommittees of the main Governing Body with delegated authority.) Dedicated time in governance meetings for RCE discussions will be reserved to ensure strong governance. For important and urgent decisions, the Executive Unit will have access to key decision makers in the governance bodies. At-least one representative on the three governance bodies will be from this unit. This unit interacts with individual Project Teams and PPS providers on a pre-scheduled basis so actionable results can be communicated to front line resources and feedback can be received.

***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.

All patient data (e.g., EHR, Claims) use will comply with data security and privacy guidelines. PPS expects substantial signed RHIO consent forms from the IDS project.

• Partner performance: Scorecards will be developed for the PPS. These will be shared transparently within the PPS and incentives and improvement plans will be linked.

• Quality: Quality scorecards at project level will be shared transparently with project teams and partners. Areas of variation in clinical results or PPS provider performance will be addressed initially at the project level. Oversight of this process will be the responsibility of the Clinical Governance Body.

•Population Health: Risk stratification into population cohorts will leverage patient data to allow for macro views and drill-downs. The ability to identify and intervene with distinct cohorts and test the efficacy of certain interventions so they can be recalibrated or scaled will be essential as a function of the Project Teams

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***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 oversight process will occur at multiple levels. The process is data-driven, decision-oriented and transparent. It also has a self-improvement aspect to account for new situations and challenges. All results from the Informatics Unit and the Executive Unit will be made available to provider/partners and Project Teams via a web-based tool. Scorecards that include all measures of success will be created for each Project Team, then rolled-up into a specific Governance Committee (Clinical/IT/or Financial), and then to a Board level scorecard for which the PPS Board will have ultimate have oversight. The pre-defined scorecard metrics will be evaluated. Communications will occur across oversight committees so key findings and decisions are pushed into the frontlines and conveyed back to leadership. Serious issues will result in corrective action for responsible entities and progress against these action plans will be tightly monitored to ensure timely completion.

***RCE 4:**

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

Our continuous improvement philosophy will draw from lean methodologies and CQI (continuous quality improvement) processes in leveraging data to guide clinical, operational and financial decision making. Our goal is to cultivate a fact-based, data-driven culture across the PPS and use it as a way to make timely, objective decisions – both strategic and day-to-day operational ones. The structure of the approach will ensure a comprehensive review of all patient data and PPS performance with recommendations and required actions that need to be taken to correct results that vary from the expected. A strong governance oversight model will ensure timely responses to the data with corrective action as needed, which will include required changes in clinical programs as well as changes needed in the performance of PPS partners or providers.

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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.

The PPS will face a number of key challenges in assuring cultural competency (CC) across all providers. These include: (1) limited knowledge of current PPS member performance and capability in CC; (2) difficulties in operationalizing CC for PPS members; (3) an unclear connection between a person's cultural bias and everyday decision making; and (4) staff turnover requiring ongoing training. To address these challenges, we will fully engage and educate key leaders and stakeholders in each PPS agency on an ongoing basis.

Many providers are not aware of the biases they bring to patient encounters or the impact that their own cultural/ethnic backgrounds, health beliefs, and practices have on the care they provide. Their goal is often to get the patient to conform to the mainstream, and not to meet them on their cultural ground. To understand more about the baseline CC in our PPS and the associated challenges, we conducted a member survey. We found that, among providers, 42% found cross-cultural communication challenging; only 7% had staff training related to care for the LGBT population; and only 7% identified disabled persons as a unique population requiring culturally competent care.

These challenges were reinforced during a recent outreach forum where 80 community leaders from churches, CBOs, the Shinnecock Indian Nation, and the Suffolk County DOH's Office of Minority Health gathered to provide perspectives on CC in healthcare. The leaders identified specific patient/provider challenges including: ineffective communication due to low health literacy and language barriers; limited provider understanding and appreciation for the cultural values of diverse populations; lack of sensitive and coordinated care for the

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elderly, disabled, LGBT, and Native Americans; limited information about community based resources; and a need for broader understanding of the diversity of the Hispanic community (multiple nationalities, unique cultures and health beliefs).

***Competency 2:**

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

The PPS will incorporate CC into all levels of its operations, expanding providers' cultural knowledge and skills to better address the needs of a diverse population. A Community Needs Assessment and Outreach Committee of the Governing Body, equally comprised of board members and representative community members, will develop/implement the strategic plan and monitor ongoing processes.

The strategic plan will focus on:
- Maintaining an understanding of community needs and demographic groups: This will elucidate the cultural issues, demographic trends, and service gaps. Ongoing PPS-wide surveys (leverging PPS-wide resources) will be conducted to evaluate the need for performance improvement and to establish specific training needs.
- Assuring information exchange relative to CC throughout the PPS: This is aimed at improving CC and informing the policies and procedures of the PPS. The PPS will host quarterly town hall meetings in-person and via webinar to inform staff of program milestones, population health trends, changing patient demographics and available resources. To provide PPS members with readily available information, EMR modules on the customs of diverse cultures will also be created.
- Improving the delivery of both existing/new services geared towards these groups: The Committee will evaluate quality of care, patient satisfaction surveys (CAHPS) and complaints, and recommend necessary corrective actions to ensure that CC.
- Developing recruitment, hiring and retention procedures of bilingual/bicultural staff, as well as training existing staff in CC. This will create an inclusive working environment by recruiting and promoting a racially, culturally and linguistically diverse workforce across all organizational levels and functions. Training programs will be specific to the needs of the populations served, using Cultural and Linguistically Appropriate Services (CLAS) standards. All providers and agency staff will be trained by the end of DY3.

***Competency 3:**

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

For decades, CBOs have played a vital role in providing culturally competent services to racial and ethnic minorities. Hispanics now make up 36% of the Medicaid population and many turn to CBOs as the only option for social, preventive and behavioral health services. Such CBOs are more likely to have higher levels of bilingual staff; extensive knowledge of cultural values and norms for target populations; experience integrating cultural practices that promote trust and confidence among patients/clients; and knowledge and access to informal, culturally-based social networks within communities that can support families. In building stronger partnerships and contracts with CBOs, the PPS will link funding levels to the provision of culturally competent care; increase funding to CBOs that provide preventive services; provide incentives for CBOs to assist in increasing the pipeline of bilingual providers; and develop and promulgate CC standards and metrics while also providing capacity building assistance to help CBOs achieve these standards.

The PPS will create ongoing opportunities for community input on policy reforms and in evaluating their implementation at the community level. An important step would be to partner with locally trusted CBOs to hold neighborhood based "town hall" meetings. This would allow diverse groups of service providers, community advocates and community members to meet with PPS leaders to address gaps in services and the efficacy of policy reform efforts and CC initiatives. Other activities in this vein might include community outreach health forums; recognizing innovative cultural competency practices (newsletters, certificates, recognition dinners, "promising practices" forums); inviting broader local input and participation in state CC initiatives; supporting innovative cultural competence pilot projects; and providing ongoing progress reports to communities on the outcomes CC efforts across the PPS.

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

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appropriate decisions about their healthcare needs and priorities. Health literacy incorporates the ability of the patient population to read, comprehend, and analyze information, weigh risks and benefits, and make decisions and take action in regards to their health care. The concept of health literacy extends to the materials, environments, and challenges specifically associated with disease prevention and health promotion.

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

***Literacy:**

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

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

In Suffolk County, two population segments face particular HL challenges: non-native English speakers and native English speakers with low literacy levels. 5% of the population lives in households with limited to no English proficiency. 17.5% of residents live below 200% of the federal poverty level and 10.2% do not have a high school education.

In implementing HL into its mission, structure, and operations, the PPS will undertake the following initiatives and actions:

• A PPS wide assessment of the organizational performance on HL;

• Development of metrics along with routine collection;

• Tracking and reporting communication failures and underlying causes;

• Assuring that consumer surveys are understandable and easy to complete;

• Conduct of widespread training of PPS personnel (onsite, online, attendance at external training, use outside experts, involvement of patients);

• Building patient self-management skills through easily understood, streamlined, written and oral instructions in the patient's preferred language. Particular attention will be given to this during care transitions and upon discharge from hospitals, emergency rooms or ambulatory facilities;

• Working with public high schools to advance student health literacy, healthy eating, exercise programs and wellness.

• Identifying and registering each patient's language preference prior to initiating care;

• Ensuring availability of translator services and supplementary visual materials as needed– especially in high risk situations involving decision making and information about medication;

• Designing and distributing print, video and social media content to address conditions with the greatest health disparities;

• Providing incentives for employees to learn new languages (i.e., reimbursement, bonus payments, and recognition) and participate in health literacy programs that are relevant to the populations being served.

In the long-term, we will seek to build HL training into the service delivery model of CBOs so that case managers and providers will routinely help clients improve their health literacy as part of their jobs. With Hispanics as the largest ethnic minority in the county, we will particularly focus on CBOs that work with these low income, low literacy, limited-English proficient communities.

We've already begun to involve CBOs in HL planning. A breakfast was held in November, 2014 for the leaders of churches and CBOs, and for members of the Shinnecock Indian Nation. The participants made recommendations for PPS-community relationships, including:

- Developing partnerships with CBOs, health centers, churches, public schools, and libraries to distribute linguistically appropriate health literature and spoken health information to educate patients on preventive screening interventions and available community resources;
- Identifying and training community peer educators on HL and providing them with educational materials; peer educators could also serve as food ambassadors with a focus on determining ways of integrating cultural dietary choices with traditional nutrition counseling;
- Working with CBOs to establishing quarterly health forums to educate consumers on specific health topics (diabetes, cancer, obesity and cardiovascular disease) and community resources;
- Working with local literacy organizations such as Literacy Suffolk, Inc. to design a range of culturally sensitive health literacy programs in plain language targeted to specific populations;

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-Establishing telemedicine sites in community health centers, senior day programs, and church organizations in areas with few community resources; and
-Link funding to the achievement of HL goals while also providing support to CBOs in achieving these standards.

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.

Plans for distribution of funds among partners - 75% of funds will be dedicated to incentivizing providers to meet and/or exceed metrics and milestones. 13.3% will be dedicated to project costs, and 5% will fund revenue losses to providers that are impacted by volume decreases resulting from DSRIP. During DY1 and DY2, there will be limited funding dedicated towards revenue loss as DSRIP's effect on reducing avoidable volumes will be subdued, allowing the funds to be dedicated to the startup costs of the eleven projects. 3.3% will fund administrative costs, 1.7% will be used for a contingency/special situation pool to support struggling safety net providers as well as to provide funding for services not currently reimbursed, and the remaining 1.7% will be dedicated to non safety net providers.

High Level Description of plan to distribute funds among Primary Care and Specialists and Other Providers on the Care Continuum - A majority of the funds flow plan is based on supporting incremental costs of implementing the eleven projects. Within each project, there will be an allocation of funds to reimburse the specific continuum-of-care safety net providers for their share of net project costs after any additional reimbursement. Furthermore, individual providers will also be eligible to share in any incentive-based performance awards based on their project meeting or exceeding metrics and milestones. Non safety-net providers will be eligible for the same type of reimbursement; however, the available funding pool would be limited to 1.7% of DSRIP funding in accordance with the DSRIP rules.

Consistency with the governance - The funds flow plan has the support of the Suffolk DSRIP's PAC and Finance Committee and has been approved by the governing body. The DSRIP's board is comprised of representatives across the spectrum of providers and clinical specialties in Suffolk County and includes representatives from: hospitals, primary care providers, behavioral health, health homes, long term care, and community based organizations.

How this supports achievement of PPS goals - The funds flow provides up to 88.3% of available funding specifically to fund project costs and incentive payments. This will allow for projects to proceed in accordance with plans put forth by the project development teams. This funding will reimburse incremental project costs after offsets for any new revenue related to the projects. The projects will drive processes

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that will enable the PPS to achieve the metrics and milestones outlined in the DSRIP application. Providers will also be incentivized as they will be able to share in any performance awards based on meeting internal and statewide metrics and milestones. There is also a process to allocate statewide reductions in the event that statewide goals are not attained.

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	13.3%
2	Revenue Loss	5%
3	Internal PPS Provider Bonus Payments	75%
4	Administration	3.3%
5	Contingency/Non-covered Services	1.7%
6	Non Safety Net	1.7%
	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 PPS has utilized the tax filings of heathcare related not-for-profits in Suffolk County to stratify risk by the entities' magnitude of revenue. Hospitals, Suffolk County, and the regional FQHC are the larger providers of healthcare services in the County.

All financial statements for all hospitals, public bond filings for those with rated debt, as well as the federal tax returns were reviewed to assess the financial condition of the hospitals. None of the hospitals would be considered financially challenged although there are many risks associated with operating a hospital in the current healthcare environment. It is reassuring that all of these hospitals made it through the "Great Recession" of 2008 as well as Hurricane Sandy in 2012 and are still financially stable.

Stony Brook has surveyed the regional FQHC which will have future responsibility for operating the County health clinics (largest Medicaid clinics). The FQHC was deemed to be financially sound. Additionally, we have begun surveying long term care providers and the providers that are limited in the region, who are relatively small but are essential to the success of individual projects. We expect the survey to be completed during the DSRIP planning phase (prior to March 2015).

The PPS has a sensitivity model that projects the range of expected revenue losses at the safety net providers and has created a plan to backfill a portion of revenue losses to give providers sufficient time to reengineer their operations.

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***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.

Historically, safety net patients have over-utilized hospitals, ERs, and Nursing Homes. The development of alternative models for delivering inpatient care will shift the services performed in the inpatient setting to community based organizations. Demand will shift from hospitals and nursing homes to lower cost settings of primary care providers, health homes, clinics, home care and behavioral health organizations.

For DSRIP to be successful, organizations will need to have the flexibility to adjust expenditures to match changes in demand. There will be shifts in employment as the demand increases for outpatient community services and decreases in the inpatient settings. There will be a redeployment and training of staff to provide them with the skill sets needed for providing care in the outpatient setting.

We have modeled the effect of the 25% reduction in avoidable hospital volume based on PQI data, avoidable readmissions, and emergency service visits and have designed a funds flow model that will backstop potential revenue losses. The funds flow model stipulates that the providers will be reimbursed for a portion of their losses related to decreases in revenue from reductions in avoidable PQI admissions, readmissions, and emergency visits. If volume declines are greater than anticipated due to DSRIP, the PPS will accelerate its plan to participate in shared savings programs with insurers in order to provide a longer transition period for hospitals to reengineer their operations to reduced volumes and related revenue.

The effect of decreasing inpatient Medicaid volumes will have a negative effect on providers who receive Bad Debt & Charity Care and Disproportionate Share revenue. The PPS will work with its MCO partners to ensure that shared savings programs are established so that the hospital can recoup any revenue losses until the necessary operational transformations are put in place.

The redesign of the reimbursement system will require a substantive shift in provider behavior as payments will be performance and value driven. This will disrupt the historical fee-for-service system that rewards volume. This will require providers to redesign their business models to adjust to the new paradigm.

Through learning collaboratives, the PPS will engage providers across the spectrum of care to provide assistance as the healthcare system transforms. Additionally, the PPS Finance Committee will monitor member's financial reports to ensure that the PPS will be able to meet its goals. In the event that a provider becomes financially unstable, a corrective action plan will be established and the PPS will support such provider(s) as needed.

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.

To ensure that the DSRIP goals are met, the Finance Committee of the PPS is developing a provider financial reporting system for operating and financial statistics which, on a quarterly basis, will be a key performance indicator of the financial health of providers in the PPS. The survey will be required for providers across the continuum-of-care, as providers overall are instrumental in achieving the DSRIP metrics and milestones. Any providers who are unable to meet the financial metrics will be required to submit a plan of correction to ensure financial stability. These providers will also be eligible to receive support from the PPS in order to implement their turn-around plan. The PPS has not identified any providers that are in need of financial restructuring at this time.

The concept of aligning the smaller independent providers with one of the regional systems or Stony Brook Medicine would allow for a more rational health system with the ability to avoid duplication of services, increase access to care, and enjoy economies of scale, as well as to provide for an increased ability to partner with insurance companies. The formation of an integrated delivery system through market forces (or perhaps with the impetus from DSRIP) will provide substantial benefits, including strengthening the providers that address the needs of underserved communities. Many such communities have historically had substantial health disparities.

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It is important to note that Stony Brook has recent success in partnering with MCOs related to value-based incentives. There has been a substantial and sustained reduction in inpatient utilization for patients who utilize the Stony Brook based-physician practices.

***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.

The funds flow design has been structured to support those providers that are essential to achieving the PPS' DSRIP goals. In addition to project related costs and incentive payments, financially fragile providers will be eligible for special situation / contingency funds.

The Suffolk PPS will monitor the financial condition of all providers that are critical to the success of the DSRIP projects. The PPS will work with any provider(s) whose financial condition deteriorates to implement a corrective action plan that will ensure that the necessary resources remain in place to meet the PPS' DSRIP goals.

***Path 3:**

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

The focus, alignment, and accountability created from establishing the Suffolk DSRIP will be key elements in ensuring the sustainability of the PPS. The ability to support providers across the continuum of care as the healthcare delivery system transitions to new business models supporting value based reimbursement will set the groundwork for a sustainable delivery system.

Key to sustaining the positive results after DSRIP will be partnering with the Medicaid Managed Care plans in delivering care and in sharing the savings generated by the reductions in avoidable hospital volumes. We plan to work with the insurance companies to develop value-based contracts that will generate additional revenue. The longer term goal of the PPS is to transition to sub-capitation models where the PPS will be at-risk and will have the potential to garner the upside in gains from a more efficient and effective health system.

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.

The PPS has one satisfactory MCO risk-sharing model in place, a foundation model that could be used with other MCOs as we partner with them to achieve the goal of having 90% VBP contracts by DY 5. An important component of these initiatives, given the more specific needs of the Medicaid patient population, will be the integration of physical and behavioral health into a comprehensive continuum of care.
The PPS has engaged several Managed Care Organizations (MCOs) in preliminary discussion of these initiatives. One leading MCO has offered details and invited further collaboration.
To insure adequacy of clinical services, the PPS has completed a market assessment and is analyzing the current state of the delivery system in relation to the PPS goals. We selected DSRIP projects that reflect the area's needs and the providers' capabilities.
The goal is to develop a payment methodology that incentivizes all constituent providers to improve quality, economies of scale and other financial efficiencies that will result in lower health care cost across the PPS. As providers will vary in their capabilities to manage the transition to VBP contracts, we will have a flexible contracting model that will match providers' ability to implement payment reform.

***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 PPS is engaged in dialogues with several MCOs regarding "pay for performance" and other value-based reimbursement initiatives. These initiatives and the resulting efficiencies will encourage MCO agreements for more incentive-based payment methodologies to further PPS quality improvements. VBP contracting will not be "one size fits all"; it will be structured to the varying needs of the PPS'

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providers. While financially sophisticated, mature providers may enter into full capitation contracts, fragile safety net providers may be better served by shared-savings models.
Through its successful risk-based contracting, the PPS has learned the value of engaged patients who act responsibly in obtaining appropriate and timely primary care. Their overall cost of care is dramatically lower than the non-engaged patient. The PPS' 11 projects will promote patient engagement and the reduction of costs in certain aspects of patient care. Through its VBP contracting, the PPS will ensure that cost-sharing contracting models are designed to support the fragile safety net providers. Our goal is to be at the 90% threshold of VBP contracting in 5 years.
Collectively, these plans and initiatives will result in sufficient financial flexibility to allow the PPS to support, to a reasonable extent, the critical operations of safety net providers that are essential to the mission of the PPS. This flexibility will afford the PPS the time to implement comprehensive remedial strategies that will either restore the provider to financial stability or allow the services to be transitioned to other PPS clinical 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.

Stony Brook's IT and Biomedical Informatics Team have extensive skills and experience in population health management. SB's CIO, Jim Murry, while working in the University of California system on DSRIP, collaborated with a national EMR vendor to design a population management platform. Through a private HIE, multiple EMRs were integrated, building a longitudinal patient record that could be shared by the patient and clinical team. These tools leveraged a "Big Data" ecosystem designed by Charles Boicey, another member of the SB team. This platform allowed for real-time rules, alerts (for patient and provider), predictive analytics and data gathering from CIS and patient devices.

Stony Brook has also recruited several experts in predictive modeling that will be supporting the implementation of DSRIP in Suffolk County. They are: Joel Saltz, MD, PhD, who developed and deployed clinical data management and predictive analytics infrastructure and methods to target potentially preventable readmissions in Emory and University HealthSystem Consortium patient populations; and Janos Hajagos PhD, Erich Bremer and Moises Eisenberg PhD who completed a variety of in-depth Medicaid population health analyses for the NYSDOH. Such analyses encompassed healthcare utilization patterns of medications/prescriptions. Results were directly integrated into the eMedNY production system for paying Medicaid claims. In addition, Stony Brook has hired xG Health Solutions, Geisinger's consulting arm, based on their 10+ years of successful population health management experience (predictive modeling and care/case management experience) supporting the 120k Medicaid lives for which they are at-risk.

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 workforce strategy is central to the Suffolk PPS achieving its DSRIP goals. The Suffolk PPS has concluded that while it has significant training abilities / capacity, no organizational member of the PPS (lead or partners) has the capacity and expertise to develop the comprehensive workforce plan needed to support DSRIP implementation. The Suffolk PPS is therefore committing to hiring a proven, independent workforce strategy consultant to conduct a workforce needs assessment, provide expertise in compensation (wages, benefits), HR processes, policies and procedures, recruitment, retention, training/retraining, and communications. This consultant will be identified through an RFP process that will have input from PPS partners and union representatives. We will consider several firms in this process including but not limited to: the 1199SEIU Training Fund, Workforce Insight, Inc., Putney, Twombly Hall & Hirson, LLP, AMN Healthcare, Inc., and ECG Management Consultants.

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

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

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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 Stony Brook University Hospital that all information provided on this Project Plan Applicant is true and accurate to the best of my knowledge.***

Primary Lead Provider Name: UNIVERSITY HOSPITAL
Secondary Lead Provider Name:

Lead Representative:	Gary Bie
Submission Date:	12/22/2014 02:58 PM

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