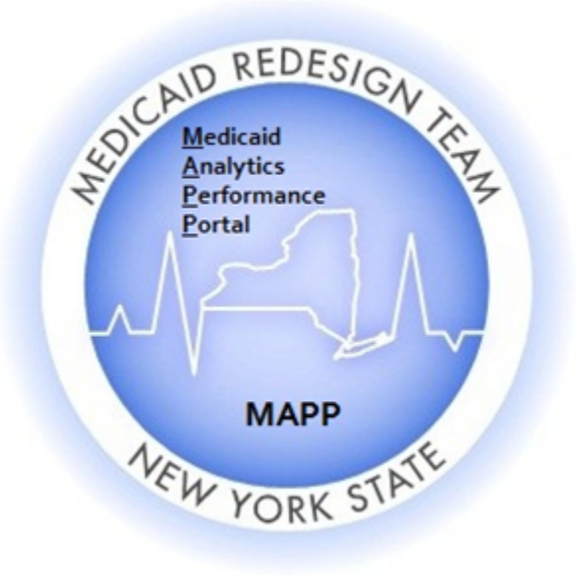
New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP PPS Organizational Application



Mount Sinai Hospitals Group

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

DSRIP PPS Organizational Application

Mount Sinai Hospitals Group (PPS ID:34)

TABLE OF CONTENTS:

Mount Sinai Hospitals Group (PPS ID:34)

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

DSRIP PPS Organizational Application

Mount Sinai Hospitals Group (PPS ID:34)

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: **34_SEC000_Mount_Sinai_Hospital_dsrip_pps_lead_financial_stability_test_application_141110.pdf**

Description of File

File Uploaded By: mssl1212
File Uploaded On: 12/22/2014 11:27 AM

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: mssl1212
Last Updated On: 12/22/2014 05:20 PM

Certified By: mssl1212
Certified On: 12/22/2014 05:20 PM
Lead Representative: Arthur Gianelli

Unlocked By:
Unlocked On:

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

DSRIP PPS Organizational Application

Mount Sinai Hospitals Group (PPS ID:34)

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	Create an integrated delivery system, reduce avoidable hospitalizations and readmissions	There is a clear need for system integration and improvements within our service area, as well as greater access to care coordination and preventive health care services. Increasingly, high-cost acute care services are utilized due to a lack of access to primary care, behavioral health services, and stabilizing social supports. In 2012, there were almost 1.2 million potentially preventable Medicaid emergency department (ED) visits (PPVs) in New York City (NYC), at a rate of 35 events per 100 members. Core components of an integrated delivery system – information sharing, medical homes, care coordination, co-location of services, use of technology, and patient-centered practices – are essential to keeping patients healthy, in the community, and out of the hospital.
2	Shift care delivery from inpatient care to coordinated, patient-centered care teams in the community	Developing coordinated patient-centered care teams will ensure that Medicaid patients receive more appropriate stabilizing services, helping to prevent conditions from escalating. PPS partners have indicated that it is extremely difficult for Medicaid beneficiaries to access all types of care with the exception of emergency services. Increasing access to ambulatory care, health education, and social services will bridge gaps within the current delivery system. By shifting the focus of care towards community-based settings and prevention, the entire health care delivery system will see a number of benefits. Patients will experience improved health outcomes and a better quality of life, while avoidable hospitalizations and health care costs will be reduced. Specialized and personalized care teams are necessary to ensure that each patient receives tailored services specific to their needs.
3	Develop the programming and infrastructure necessary to manage population health	A population health approach that expands beyond the Medicaid population will have broad benefits for patients, providers, payers, and society. However, providing the right care at the right time – from prevention, to treatment, to end of life care – requires a more balanced distribution of primary and preventive health care resources and facilities in the community, as well as programming and personnel to support personal health and healthy habits. We can improve health outcomes for the entire community by: 1) implementing technologies to share information, track patient behavior, and provide follow up and treatment more easily; 2) expanding social services and primary care and behavioral health service sites in the community; 3) and investing in care coordinators and health navigators.
4	Move towards a value-based and capitated payment	To achieve population health and improve health outcomes for the entire

Mount Sinai Hospitals Group (PPS ID:34)

#	Goal	Reason For Goal
	model to manage costs across the continuum	service area, health care utilization patterns must shift and costs must be reduced. On the other hand, to move towards a value-based payment model, the system must already have key components in place to manage population health that allows partners to evolve towards risk. DSRIP provides an unprecedented opportunity to transition towards a value-based payment model while implementing systems change reforms. These simultaneous trajectories will realign provider incentives across our spectrum of care towards less costly preventive outpatient care, support all provider partners in care delivery transformation and payment reform, and ultimately create value for consumers and payors. More importantly, DSRIP provides a critical opportunity to build trust across the PPS network of providers. This trust will support and enable our partners to participate in shared risk arrangements in the future.

***Formulation:**

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

The Mount Sinai Performing Provider System (MSPPS) includes a wide spectrum of providers. Our partners offer culturally and linguistically appropriate services in medically underserved areas, serving some of the most hard-to-reach and chronically ill patients, as well as the general Medicaid population. Patient populations include those with developmental disabilities, diabetes, severe mental illness, HIV/AIDS, and individuals with co-occurring chronic conditions. Special consideration was given to include partners across the full spectrum of health and social services. We recruited behavioral health agencies, CBOs, nursing homes, and primary care physicians, because these services were identified as lacking in our CNA.

The MSPPS worked diligently to be collaborative and transparent, sharing information and soliciting feedback to understand community needs and the barriers low-income individuals face in accessing need health services and social supports. Open Project Advisory Committee (PAC) meetings, regular Town Halls, weekly newsletters, continuous partner surveys, and community presentations were purposefully implemented to facilitate this level of dialogue.

***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.

Our vision for the delivery system is a sustainable, population-health driven model, providing high quality care regardless of payor. Increased access to primary, urgent, and behavioral health care in community settings will be achieved through coordinated workforce investments, support of frontline providers and workers, implementation of patient support services, and the restructuring of infrastructure. Integration will occur through care coordination and navigation, co-location of services, and a common data-sharing platform. Ensuring long-term financial stability of this system requires supporting partners in making the transition to risk contracts capable of receiving value-based and capitated payments for our Medicaid population. The Mount Sinai Health System (which encompasses seven hospital sites, the Icahn School of Medicine, the Mount Sinai MSO, Provider Partners of Mount Sinai IPA, and the Mount Sinai IPA) and the MSPPS will develop new structures best suited to accomplish this from a regulatory and legal perspective. Initially, the MSPPS will be an LLC, but a clinically integrated IPA or ACO may also be established. The Mount Sinai Hospital is serving as lead entity.

***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 86-4.9 – Units of Service	All MSPPS selected projects will require the participation of sites with co-located services in order to seamlessly integrate services and achieve the goals of DSRIP. Specifically, the entire focus of Project 3.a.i is centered on the co-location of behavioral health and primary care services. The need for behavioral health services among the patient populations targeted in each project is pronounced, specifically the behavioral health population in Project 3.a.i and 3.a.iii, and additionally individuals with co-occuring behavioral health disorders targeted in Project 3.b.i (cardiovascular conditions), 3.c.i (diabetes), and 4.c.ii (HIV/AIDS). All projects require greater coordination of care and increased access to preventive care, which can be enhanced through co-located behavioral health, primary care, and other needed clinical services. Projects 2.b.iv and 2.b.viii require greater care coordination and increased access to services within a timeframe to prevent hospital readmissions for highly complex patient populations. These populations include individuals with co-morbidities, mobility issues and transportation barriers, and poor health literacy. The availability of co-located services in one-stop clinics will greatly increase the ability of care coordinators, case managers, and community health navigators to ensure patient adherence to care plans and access to needed services. Single threshold regulations prohibit free-standing ambulatory care facilities from billing for more than one "threshold visit" per day. This applies to FQHCs as well as other clinics. DOH should waive 86-4.9 limiting reimbursement to only one threshold visit per day, if the services provided on the same day if the services are of different types (e.g., medical, dental, and behavioral services should each be billable on a particular day), and the services are provided by an MSPPS member. Failure to modify this regulation will create a roadblock in accessing to behavioral health and other services types and inhibit the achievement of DSRIP outcomes. Patient safety should not be affected because the sites involve only already-licensed operators. Safety will likely be enhanced because of the availability of multidisciplinary services, which will improve the ability of patients to receive needed care in a timely manner.
2	10 NYCRR 86-4.9(i) – Units of Service and FQHC Offsite Services	A key goal of DSRIP is to provide patients with the right care, at the right time, and in the right place. All Mount Sinai PPS selected projects will require the participation of clinical sites that have the flexibility to serve patients that may not have the capacity to receive care onsite. These patients may be too sick, frail, and/or lack transportation to visit a clinic. Regulations prohibit payment for FQHC services if provided to patients whose status is expected to permanently preclude return to the FQHC. Regulations also limit the provision of off-site services to physicians, PAs, midwives and nurse practitioners. FQHCs should have flexibility to offer services to patients who may not

Mount Sinai Hospitals Group (PPS ID:34)

#	Regulatory Relief(RR)	RR Response
		return to on-site status, and also to offer off-site services of dental providers, social workers and nurses. Failure to modify this regulation will hinder the ability of key DSRIP primary care providers from serving populations with the highest level of needs and least access to care. This should not affect patient safety adversely and in fact will improve the ability of patients to receive needed care in a timely manner.
3	10 NYCRR Part 86 Subpart 86-1 Medical Facilities	All MSPPS selected projects will require the development of a clinically integrated health system with seamless coordination of care. In particular, Projects 2.a.i, 2.b.iv, and 4.b.ii will drive a restructuring of hospital services to improve population health by serving outpatient needs in the community while increasing access to specialized services requiring an inpatient setting. Over time, this will result in the reduction of excess hospital capacity, supporting a focus on providing high quality evidence-based inpatient care when medically appropriate. Consistency of financial reimbursement for services to Medicaid patients across the MSPPS will be essential to achieving the necessary facility restructuring and integration. MSPPS expects that a modification of 10 NYCRR 86-1.31 and related rate calculation sections may be necessary to support its hospital partners in achieving this consistency during this period of system transformation. Modification of this regulation would not raise any concern for patient safety and would enhance the ability of MSPPS partners to deliver high quality care.
4	10 NYCRR Part 600	All MSPPS selected projects will require the participation of sites with co-located services in order to seamlessly integrate services and achieve the goals of DSRIP. Specifically, the entire focus of Project 3.a.i is centered on the co-location of behavioral health and primary care services. The need for behavioral health services among the patient populations targeted in each project is pronounced, specifically the behavioral health population in Project 3.a.i and 3.a.iii, and additionally individuals with co-occuring behavioral health disorders targeted in Project 3.b.i (cardiovascular conditions), 3.c.i (diabetes), and 4.c.ii (HIV/AIDS). All projects require greater coordination of care and increased access to preventive care, which can be enhanced through co-located behavioral health, primary care, and other needed clinical services. Projects 2.b.iv and 2.b.viii require greater care coordination and increased access to services within a timeframe to prevent hospital readmissions for highly complex patient populations. These populations include individuals with co-morbidities, mobility issues and transportation barriers, and poor health literacy. The availability of co-located services in one-stop clinics will greatly increase the ability of care coordinators, case managers, and community health navigators to ensure patient adherence to care plans and access to needed services. The addition of any primary care, behavioral or substance abuse services by a licensed MSPPS participant should not be required to establish need or prove financial feasibility under 10 NYCRR Part 600 or 670. In order to implement DSRIP projects within the prescribed timeframe, service providers will need to adapt quickly and meet an increased demand for behavioral health. The time consuming effort of demonstrating the financial feasibility of a project required to obtain a Certificate of Need is not realistic within the given timeframe of implementation. Furthermore, financial feasibility of most DSRIP projects will be based not only on the ability of the entire PPS to achieve DSRIP outcomes, but also on statewide DSRIP outcomes. Patient safety should not be affected because the sites involve only

Mount Sinai Hospitals Group (PPS ID:34)

#	Regulatory Relief(RR)	RR Response
		already-licensed operators and the applicable space will meet life safety requirements generally. Safety will likely be enhanced because of the availability of multidisciplinary services, which will improve the ability of patients to receive needed care in a timely manner.
5	10 NYCRR Part 703 (Ambulatory Services)	All MSPPS selected projects will require the participation of sites with co-located services in order to seamlessly integrate services and achieve the goals of DSRIP. Specifically, the entire focus of Project 3.a.i is centered on the co-location of behavioral health and primary care services. The need for behavioral health services among the patient populations targeted in each project is pronounced, specifically the behavioral health population in Project 3.a.i and 3.a.iii, and additionally individuals with co-occuring behavioral health disorders targeted in Project 3.b.i (cardiovascular conditions), 3.c.i (diabetes), and 4.c.ii (HIV/AIDS). All projects require greater coordination of care and increased access to preventive care, which can be enhanced through co-located behavioral health, primary care, and other needed clinical services. Projects 2.b.iv and 2.b.viii require greater care coordination and increased access to services within a timeframe to prevent hospital readmissions for highly complex patient populations. These populations include individuals with co-morbidities, mobility issues and transportation barriers, and poor health literacy. The availability of co-located services in one-stop clinics will greatly increase the ability of care coordinators, case managers, and community health navigators to ensure patient adherence to care plans and access to needed services. Pursuant to 703.2, Article 31 or Article 32 facilities must meet all of the requirements of Chapter V of the DOH regulations (i.e., all CON, licensure and related regulations applicable to Article 28 sites.) Any licensed MHL Article 31 or Article 32 provider that adds ambulatory health care services (provided that such services are less than half of the services offered at the applicable location) should not be required to independent satisfy the requirements of 10 NYCRR 703.2, 703.3, 703.4, and 703.6. In order to co-locate services through Project 3a.i and integrate care across the delivery system to meet the requirement of all DSRIP projects, Article 31 and 32 licensed facilities will need to add primary care. To do so within the given timeframe of DSRIP, they should not have to independently meet A28 requirements. Patient safety should not be affected because the sites involve only already-licensed operators and the applicable space will meet life safety requirements generally. Safety will likely be enhanced because of the availability of multidisciplinary services, which will improve the ability of patients to receive needed care in a timely manner.
6	10 NYCRR Part 710 (Approval of Medical Facility Construction)	We anticipate that integrating the delivery system through Project 2.a.i will require a significant restructuring of the MSPPS health care infrastructure and a shift care from costly inpatient hospital use to outpatient care. This will require downsizing of provider capacity based on a systematic formal analysis of excess beds. Approval of new Article 28 Facility construction in conjunction with downsizing should be limited to administrative review 10 NYCRR 710.1(c)(2) and (3), provided that no new services are added that are specified in 710.1(c)(2)(i)(b). In order to implement DSRIP projects within the prescribed timeframe and achieve DSRIP, hospitals will need implement infrastructure changes that

Mount Sinai Hospitals Group (PPS ID:34)

#	Regulatory Relief(RR)	RR Response
		will drive this shift in the delivery of care quickly. Limiting downsizing of Article 28 construction to administrative review will ensure that this shift occurs. Under this request, downsizing would be subject to administrative review to safeguard against any potential impacts to patient safety.
7	10 NYCRR Part 710 (Approval of Medical Facility Construction)	10 NYCRR Part 710 (Approval of Medical Facility Construction) Related to certificates of need and prior approvals should be liberalized to permit more flexible use of resources All MSPPS selected projects will require the participation of sites with co-located services in order to seamlessly integrate services and achieve the goals of DSRIP. Specifically, the entire focus of Project 3.a.i is centered on the co-location of behavioral health and primary care services. The need for behavioral health services among the patient populations targeted in each project is pronounced, specifically the behavioral health population in Project 3.a.i and 3.a.iii, and additionally individuals with co-occuring behavioral health disorders targeted in Project 3.b.i (cardiovascular conditions), 3.c.i (diabetes), and 4.c.ii (HIV/AIDS). All projects require greater coordination of care and increased access to preventive care, which can be enhanced through co-located behavioral health, primary care, and other needed clinical services. Projects 2.b.iv and 2.b.viii require greater care coordination and increased access to services within a timeframe to prevent hospital readmissions for highly complex patient populations. These populations include individuals with co-morbidities, mobility issues and transportation barriers, and poor health literacy. The availability of co-located services in one-stop clinics will greatly increase the ability of care coordinators, case managers, and community health navigators to ensure patient adherence to care plans and access to needed services. Limited review (10 NYCRR Part 710.1(c)(5) should be applied to: -The integration of mental health services into an already established site providing medical or health services, and such review should substitute for other agency review. -Any expenditures for health information technology. For projects that require construction, if the construction is limited making changes to the floor plan consistent with co-location of health and mental health services, permit self-certification of architectural approvals (10 NYCRR 710.4 and 710.6) and provide for waiver or presumptive approval of inspections (10 NYCRR 710.9). Applicants will be required to conduct architectural reviews and will ultimately be responsible for corrective action if the reviews were not proper or complete. This will permit more rapid adoption of new programs but should not adversely affect patient safety.
8	10 NYCRR Part 710 and 10 NYCRR 401.3(e)	10 NYCRR Part 710 and 10 NYCRR 401.3(e)(Approval of Medical Facility Construction and Changes in Existing Facilities) We anticipate that integrating the delivery system through Project 2.a.i will require a significant restructuring of the MSPPS health care infrastructure and a shift care from costly inpatient hospital use to outpatient care. This will require downsizing of hospital capacity based on a systematic formal analysis of excess beds. Decertification of services or bed reductions should be subject only to limited review, regardless of scope or expense of project. Also requires waiver of 10 NYCRR 401.3(e).

Mount Sinai Hospitals Group (PPS ID:34)

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9	14 NYCRR 551 (Prior Approval Review for Quality and Appropriateness)	All MSPPS selected projects will require the participation of sites with co-located services in order to seamlessly integrate services and achieve the goals of DSRIP. Specifically, the entire focus of Project 3.a.i is centered on the co-location of behavioral health and primary care services. The need for behavioral health services among the patient populations targeted in each project is pronounced, specifically the behavioral health population in Project 3.a.i and 3.a.iii, and additionally individuals with co-occurring behavioral health disorders targeted in Project 3.b.i (cardiovascular conditions), 3.c.i (diabetes), and 4.c.ii (HIV/AIDS). All projects require greater coordination of care and increased access to preventive care, which can be enhanced through co-located behavioral health, primary care, and other needed clinical services. Projects 2.b.iv and 2.b.viii require greater care coordination and increased access to services within a timeframe to prevent hospital readmissions for highly complex patient populations. These populations include individuals with co-morbidities, mobility issues and transportation barriers, and poor health literacy. The availability of co-located services in one-stop clinics will greatly increase the ability of care coordinators, case managers, and community health navigators to ensure patient adherence to care plans and access to needed services. Permit existing providers of behavioral health services to add additional locations (provided that such locations are licensed under Articles 31 or 32 of the MHL or Article 28 of the PHL), without undergoing regulatory review. Specifically, waive 551.2(a) requiring an operating certificate. Expansion to primary care sites should be automatic if a component of an approved MSPPS project. Section 551.6(c) approvals related to program changes should be waived pertaining to such satellite clinics. Section 551.6(d) regarding changes in program location should be waived. Patient safety should not be affected because the new sites involve only already-licensed operators and the applicable space will meet life safety requirements generally. Safety will likely be enhanced because of the availability of multidisciplinary services, which will improve the ability of patients to receive needed care in a timely manner.
10	14 NYCRR 587 (Operation of Outpatient Programs)	All MSPPS selected projects will require the participation of sites with co-located services in order to seamlessly integrate services and achieve the goals of DSRIP. Specifically, the entire focus of Project 3.a.i is centered on the co-location of behavioral health and primary care services. The need for behavioral health services among the patient populations targeted in each project is pronounced, specifically the behavioral health population in Project 3.a.i and 3.a.iii, and additionally individuals with co-occurring behavioral health disorders targeted in Project 3.b.i (cardiovascular conditions), 3.c.i (diabetes), and 4.c.ii (HIV/AIDS). All projects require greater coordination of care and increased access to preventive care, which can be enhanced through co-located behavioral health, primary care, and other needed clinical services. Projects 2.b.iv and 2.b.viii require greater care coordination and increased access to services within a timeframe to prevent hospital readmissions for highly complex patient populations. These populations include individuals with co-morbidities, mobility issues and transportation barriers, and poor health literacy. The availability of co-located services in one-stop clinics will greatly increase the ability of care coordinators, case managers, and community

Mount Sinai Hospitals Group (PPS ID:34)

#	Regulatory Relief(RR)	RR Response
		health navigators to ensure patient adherence to care plans and access to needed services. 587.2(b) prohibits outpatient programs without an operating certificate. This will limit the ability to open new programs through the coordination of two existing already-licensed providers. 587.5(h) limits changes in physical space, location, use of additional sites and change in capacity. These requirements should be waived to permit joint programs among already-licensed providers under PHL Article 28, or MHL 31 and/or 32. For the purpose of calculation of staffing requirements under 14 NYCRR 587.15, to allow for flexible staffing at multiple sites, staffing ratios should be consolidated to central service site. (Patient safety should not be adversely affected because staffing ratios will still be maintained at the provider, and the remote site will be co-located with another licensed provider entity.) Overall, patient safety should not be affected because the new sites involve only already-licensed operators and the applicable space will meet life safety requirements generally. Safety will likely be enhanced because of the availability of multidisciplinary services, which will improve the ability of patients to receive needed care in a timely manner.
11	14 NYCRR 588.5 (Medical Assistance Payment to Outpatient Programs)	All MSPPS selected projects will require the participation of sites with co-located services in order to seamlessly integrate services and achieve the goals of DSRIP. Specifically, the entire focus of Project 3.a.i is centered on the co-location of behavioral health and primary care services. The need for behavioral health services among the patient populations targeted in each project is pronounced, specifically the behavioral health population in Project 3.a.i and 3.a.iii, and additionally individuals with co-occuring behavioral health disorders targeted in Project 3.b.i (cardiovascular conditions), 3.c.i (diabetes), and 4.c.ii (HIV/AIDS). All projects require greater coordination of care and increased access to preventive care, which can be enhanced through co-located behavioral health, primary care, and other needed clinical services. Projects 2.b.iv and 2.b.viii require greater care coordination and increased access to services within a timeframe to prevent hospital readmissions for highly complex patient populations. These populations include individuals with co-morbidities, mobility issues and transportation barriers, and poor health literacy. The availability of co-located services in one-stop clinics will greatly increase the ability of care coordinators, case managers, and community health navigators to ensure patient adherence to care plans and access to needed services. 14 NYCRR Part 588.5 is a provision that requires, among other things, that any program should have a valid operating certificate issued by OMH. To effectively co-locate services and provide behavioral health services at a primary care site, not only must providers comply with the substantive requirements of Part 587, but they will not be paid for services unless they meet the requirements of 588. No OMH operating certificate should be required for a location whose expansion or operation is approved due to waivers pursuant to an approved DSRIP program in order for the applicable program to receive reimbursement.

Mount Sinai Hospitals Group (PPS ID:34)

#	Regulatory Relief(RR)	RR Response
		Patient safety should not be affected because the sites involve only already-licensed operators and the applicable space will meet life safety requirements generally. Safety will likely be enhanced because of the availability of multidisciplinary services, which will improve the ability of patients to receive needed care in a timely manner.
12	10 NYCRR 791.2 (Hospice Operation – General Provisions)	The goal of Project 2.b.viii is to reduce 30-day hospital readmissions for Medicaid beneficiaries discharged into home care. Through care coordination and wrapping the target patient population with all needed services, including hospice and palliative care, the project will address patients' underlying health and social service needs that drive hospital readmissions. Hospice and palliative care services that reduce patient pain and discomfort are key to better meeting the needs of this population, but are lacking within the service area. In addition, in order to integrate services across the entire service area as required by DSRIP and Project 2.a.i, hospice providers will need the flexibility to serve patients within the entire MSPPS service area. 10 NYCRR 791.2 requires a hospice to obtain approval for any change to its geographic service area. This requirement should be waived for a hospice that participates in the MSPPS, and that receives a patient referred by another MSPPS member in which the hospice and the MSPPS member are engaged in a care coordination program. Expanding the service area of already licensed providers should not adversely affect patient safety.
13	10 NYCRR 762.2 (specifically, 762.2(c))	10 NYCRR 762.2 (specifically, 762.2(c)) (Certified Home Health Agencies and Licensed Home Care Services Agencies; Approval of Home Care Programs and Program Changes) The goal of Project 2.b.viii is to reduce 30-day hospital readmissions for Medicaid beneficiaries discharged into home care. Through care coordination and wrapping the target patient population with all needed services, the project will engage home care providers to address patients' underlying health and social service needs that drive hospital readmissions through multidisciplinary teams and greater care coordination. This effort is part in parcel of the greater goal of DSRIP and Project 2.a.i to integrate services across the entire service area. To accomplish these goals, home care providers will need the flexibility to serve patients within the entire MSPPS service area. 10 NYCRR 762.2 requires a certified home health agency or a long term home health care program to obtain approval for a change in the program's geographic service area. This requirement should be waived for any agency that participates in the MSPPS, and that receives a patient referred by another MSPPS member in which the agency and the MSPPS member are engaged in a care coordination program. Expanding the service area of already licensed providers should not adversely affect patient safety.
14	10 NYCRR 599 (Clinic Treatment Programs)	All MSPPS selected projects will require the participation of sites with co-located services in order to seamlessly integrate services and achieve the goals of DSRIP. Specifically, the entire focus of Project 3.a.i is centered on the co-location of behavioral health and primary care services. The need for behavioral health services among the patient populations targeted in each project is pronounced, specifically the behavioral health population in Project 3.a.i and 3.a.iii, and additionally individuals with co-occuring behavioral health disorders targeted in Project 3.b.i (cardiovascular

Mount Sinai Hospitals Group (PPS ID:34)

#	Regulatory Relief(RR)	RR Response
		conditions), 3.c.i (diabetes), and 4.c.ii (HIV/AIDS). All projects require greater coordination of care and increased access to preventive care, which can be enhanced through co-located behavioral health, primary care, and other needed clinical services. Projects 2.b.iv and 2.b.viii require greater care coordination and increased access to services within a timeframe to prevent hospital readmissions for highly complex patient populations. These populations include individuals with co-morbidities, mobility issues and transportation barriers, and poor health literacy. The availability of co-located services in one-stop clinics will greatly increase the ability of care coordinators, case managers, and community health navigators to ensure patient adherence to care plans and access to needed services. 14 NYCRR 599.2 prohibits the operation of outpatient programs for persons with mental illness without an operating certificate issued by the commissioner of mental health. 14 NYCRR 599.5(e)(1) requires satellite operations of clinics to be approved under Part 551. 14 NYCRR 599.5(f) and (g), require OMH approval for changing hours of operation or establishment of a new program. 14 NYCRR 599.14 should be waived as to the maximum number of payable claims per day (only three Medicaid claims per day are permitted) if the services are provided at a multi-disciplinary site and consist of a mix of services. Any expansion site operating at a site approved to provide medical or health services or substance abuse services should be deemed approved under Section 551 and satisfying the applicable 599 requirements. Patient safety should not be affected because the expanded sites involve only already-licensed operators and the applicable space will meet life safety requirements generally. Safety will likely be enhanced because of the availability of multidisciplinary services, which will improve the ability of patients to receive needed care in a timely manner.
15	10 NYCRR 86-4.9(i) – Units of Service and FQHC Offsite Services	A key goal of DSRIP is to provide patients with the right care, at the right time, and in the right place. All Mount Sinai PPS selected projects will require the participation of clinical sites that have the flexibility to serve patients that may not have the capacity to receive care onsite. These patients may be too sick, frail, and/or lack transportation to visit a clinic. Regulations prohibit payment for FQHC services if provided to patients whose status is expected to permanently preclude return to the FQHC. Regulations also limit the provision of off-site services to physicians, PAs, midwives and nurse practitioners. FQHCs should have flexibility to offer services to patients who may not return to on-site status, and also to offer off-site services of dental providers, social workers and nurses. Failure to modify this regulation will hinder the ability of key DSRIP primary care providers from serving populations with the highest level of needs and least access to care. This should not affect patient safety adversely and in fact will improve the ability of patients to receive needed care in a timely manner.
16	10 NYCRR Part 86 Subpart 86-1 Medical Facilities	All MSPPS selected projects will require the development of a clinically integrated health system with seamless coordination of care. In particular, Projects 2.a.i, 2.b.iv, and 4.b.ii will drive a restructuring of hospital services to improve population health by serving outpatient needs in the community

Mount Sinai Hospitals Group (PPS ID:34)

#	Regulatory Relief(RR)	RR Response
		while increasing access to specialized services requiring an inpatient setting. Over time, this will result in the reduction of excess hospital capacity, supporting a focus on providing high quality evidence-based inpatient care when medically appropriate. Consistency of financial reimbursement for services to Medicaid patients across the MSPSS will be essential to achieving the necessary facility restructuring and integration. A clarification of 10 NYCRR 86-1.31 would support MSPPS's hospital partners in achieving this consistency. General hospitals joining under the common control of the same active parent entity for purposes of creating a more economical common enterprise should qualify as a "merger, acquisition and consolidation" as used in 10 NYCRR 86-1.31. Payments for such hospitals should be calculated based on the Subpart 86-1 rate factors of the hospital with the highest pre-combination rate. This would allow all combining hospitals to operate under consistent reimbursement rates while reinforcing DOH's commitment to supporting providers during this period of system transformation. Modification of this regulation would not raise any concern for patient safety and would enhance the ability of MSPPS partners to deliver high quality care.
17	10 NYCRR Part 600	All MSPPS selected projects will require the participation of sites with co-located services in order to seamlessly integrate services and achieve the goals of DSRIP. Specifically, the entire focus of Project 3.a.i is centered on the co-location of behavioral health and primary care services. The need for behavioral health services among the patient populations targeted in each project is pronounced, specifically the behavioral health population in Project 3.a.i and 3.a.iii, and additionally individuals with co-occuring behavioral health disorders targeted in Project 3.b.i (cardiovascular conditions), 3.c.i (diabetes), and 4.c.ii (HIV/AIDS). All projects require greater coordination of care and increased access to preventive care, which can be enhanced through co-located behavioral health, primary care, and other needed clinical services. Projects 2.b.iv and 2.b.viii require greater care coordination and increased access to services within a timeframe to prevent hospital readmissions for highly complex patient populations. These populations include individuals with co-morbidities, mobility issues and transportation barriers, and poor health literacy. The availability of co-located services in one-stop clinics will greatly increase the ability of care coordinators, case managers, and community health navigators to ensure patient adherence to care plans and access to needed services. The addition of any primary care, behavioral or substance abuse services by a licensed MSPPS participant should not be required to establish need or prove financial feasibility under 10 NYCRR Part 600 or 670. In order to implement DSRIP projects within the prescribed timeframe, service providers will need to adapt quickly and meet an increased demand for behavioral health. The time consuming effort of demonstrating the financial feasibility of a project required to obtain a Certificate of Need is not realistic within the given timeframe of implementation. Furthermore, financial feasibility of most DSRIP projects will be based not only on the ability of the entire PPS to achieve DSRIP outcomes, but also on statewide DSRIP outcomes. Patient safety should not be affected because the sites involve only already-licensed operators and the applicable space will meet life safety requirements generally. Safety will likely be enhanced because of the availability of multidisciplinary services, which will improve the ability of

Mount Sinai Hospitals Group (PPS ID:34)

#	Regulatory Relief(RR)	RR Response
		patients to receive needed care in a timely manner.
18	10 NYCRR Part 703 (Ambulatory Services)	All MSPPS selected projects will require the participation of sites with co-located services in order to seamlessly integrate services and achieve the goals of DSRIP. Specifically, the entire focus of Project 3.a.i is centered on the co-location of behavioral health and primary care services. The need for behavioral health services among the patient populations targeted in each project is pronounced, specifically the behavioral health population in Project 3.a.i and 3.a.iii, and additionally individuals with co-occuring behavioral health disorders targeted in Project 3.b.i (cardiovascular conditions), 3.c.i (diabetes), and 4.c.ii (HIV/AIDS). All projects require greater coordination of care and increased access to preventive care, which can be enhanced through co-located behavioral health, primary care, and other needed clinical services. Projects 2.b.iv and 2.b.viii require greater care coordination and increased access to services within a timeframe to prevent hospital readmissions for highly complex patient populations. These populations include individuals with co-morbidities, mobility issues and transportation barriers, and poor health literacy. The availability of co-located services in one-stop clinics will greatly increase the ability of care coordinators, case managers, and community health navigators to ensure patient adherence to care plans and access to needed services. Pursuant to 703.2, Article 31 or Article 32 facilities must meet all of the requirements of Chapter V of the DOH regulations (i.e., all CON, licensure and related regulations applicable to Article 28 sites.) Any licensed MHL Article 31 or Article 32 provider that adds ambulatory health care services (provided that such services are less than half of the services offered at the applicable location) should not be required to independent satisfy the requirements of 10 NYCRR 703.2, 703.3, 703.4, and 703.6. In order to co-locate services through Project 3a.i and integrate care across the delivery system to meet the requirement of all DSRIP projects, Article 31 and 32 licensed facilities will need to add primary care. To do so within the given timeframe of DSRIP, they should not have to independently meet A28 requirements. Patient safety should not be affected because the sites involve only already-licensed operators and the applicable space will meet life safety requirements generally. Safety will likely be enhanced because of the availability of multidisciplinary services, which will improve the ability of patients to receive needed care in a timely manner.
19	10 NYCRR Part 710 (Approval of Medical Facility Construction)	We anticipate that integrating the delivery system through Project 2.a.i will require a significant restructuring of the MSPPS health care infrastructure and a shift care from costly inpatient hospital use to outpatient care. This will require downsizing of provider capacity based on a systematic formal analysis of excess beds. Approval of new Article 28 Facility construction in conjunction with downsizing should be limited to administrative review 10 NYCRR 710.1(c)(2) and (3), provided that no new services are added that are specified in 710.1(c)(2)(i)(b). In order to implement DSRIP projects within the prescribed timeframe and achieve DSRIP, hospitals will need implement infrastructure changes that will drive this shift in the delivery of care quickly. Limiting downsizing of Article 28 construction to administrative review will ensure that this shift occurs.

Mount Sinai Hospitals Group (PPS ID:34)

#	Regulatory Relief(RR)	RR Response
		Under this request, downsizing would be subject to administrative review to safeguard against any potential impacts to patient safety.
20	10 NYCRR Part 710 (Approval of Medical Facility Construction)	10 NYCRR Part 710 (Approval of Medical Facility Construction) Related to certificates of need and prior approvals should be liberalized to permit more flexible use of resources All MSPPS selected projects will require the participation of sites with co-located services in order to seamlessly integrate services and achieve the goals of DSRIP. Specifically, the entire focus of Project 3.a.i is centered on the co-location of behavioral health and primary care services. The need for behavioral health services among the patient populations targeted in each project is pronounced, specifically the behavioral health population in Project 3.a.i and 3.a.iii, and additionally individuals with co-occuring behavioral health disorders targeted in Project 3.b.i (cardiovascular conditions), 3.c.i (diabetes), and 4.c.ii (HIV/AIDS). All projects require greater coordination of care and increased access to preventive care, which can be enhanced through co-located behavioral health, primary care, and other needed clinical services. Projects 2.b.iv and 2.b.viii require greater care coordination and increased access to services within a timeframe to prevent hospital readmissions for highly complex patient populations. These populations include individuals with co-morbidities, mobility issues and transportation barriers, and poor health literacy. The availability of co-located services in one-stop clinics will greatly increase the ability of care coordinators, case managers, and community health navigators to ensure patient adherence to care plans and access to needed services. Limited review (10 NYCRR Part 710.1(c)(5) should be applied to: -The integration of mental health services into an already established site providing medical or health services, and such review should substitute for other agency review. -Any expenditures for health information technology. For projects that require construction, if the construction is limited making changes to the floor plan consistent with co-location of health and mental health services, permit self-certification of architectural approvals (10 NYCRR 710.4 and 710.6) and provide for waiver or presumptive approval of inspections (10 NYCRR 710.9). Applicants will be required to conduct architectural reviews and will ultimately be responsible for corrective action if the reviews were not proper or complete. This will permit more rapid adoption of new programs but should not adversely affect patient safety.
21	10 NYCRR Part 710 and 10 NYCRR 401.3(e)	10 NYCRR Part 710 and 10 NYCRR 401.3(e)(Approval of Medical Facility Construction and Changes in Existing Facilities) We anticipate that integrating the delivery system through Project 2.a.i will require a significant restructuring of the MSPPS health care infrastructure and a shift care from costly inpatient hospital use to outpatient care. This will require downsizing of hospital capacity based on a systematic formal analysis of excess beds. Decertification of services or bed reductions should be subject only to limited review, regardless of scope or expense of project. Also requires waiver of 10 NYCRR 401.3(e).
22	14 NYCRR 551 (Prior Approval Review for Quality and Appropriateness)	All MSPPS selected projects will require the participation of sites with co-located services in order to seamlessly integrate services and achieve the goals of DSRIP. Specifically, the entire focus of Project 3.a.i is centered on the co-location of behavioral health and primary care services. The need for

Mount Sinai Hospitals Group (PPS ID:34)

#	Regulatory Relief(RR)	RR Response
		behavioral health services among the patient populations targeted in each project is pronounced, specifically the behavioral health population in Project 3.a.i and 3.a.iii, and additionally individuals with co-occurring behavioral health disorders targeted in Project 3.b.i (cardiovascular conditions), 3.c.i (diabetes), and 4.c.ii (HIV/AIDS). All projects require greater coordination of care and increased access to preventive care, which can be enhanced through co-located behavioral health, primary care, and other needed clinical services. Projects 2.b.iv and 2.b.viii require greater care coordination and increased access to services within a timeframe to prevent hospital readmissions for highly complex patient populations. These populations include individuals with co-morbidities, mobility issues and transportation barriers, and poor health literacy. The availability of co-located services in one-stop clinics will greatly increase the ability of care coordinators, case managers, and community health navigators to ensure patient adherence to care plans and access to needed services. Permit existing providers of behavioral health services to add additional locations (provided that such locations are licensed under Articles 31 or 32 of the MHL or Article 28 of the PHL), without undergoing regulatory review. Specifically, waive 551.2(a) requiring an operating certificate. Expansion to primary care sites should be automatic if a component of an approved MSPPS project. Section 551.6(c) approvals related to program changes should be waived pertaining to such satellite clinics. Section 551.6(d) regarding changes in program location should be waived. Patient safety should not be affected because the new sites involve only already-licensed operators and the applicable space will meet life safety requirements generally. Safety will likely be enhanced because of the availability of multidisciplinary services, which will improve the ability of patients to receive needed care in a timely manner.
23	14 NYCRR 587 (Operation of Outpatient Programs)	All MSPPS selected projects will require the participation of sites with co-located services in order to seamlessly integrate services and achieve the goals of DSRIP. Specifically, the entire focus of Project 3.a.i is centered on the co-location of behavioral health and primary care services. The need for behavioral health services among the patient populations targeted in each project is pronounced, specifically the behavioral health population in Project 3.a.i and 3.a.iii, and additionally individuals with co-occurring behavioral health disorders targeted in Project 3.b.i (cardiovascular conditions), 3.c.i (diabetes), and 4.c.ii (HIV/AIDS). All projects require greater coordination of care and increased access to preventive care, which can be enhanced through co-located behavioral health, primary care, and other needed clinical services. Projects 2.b.iv and 2.b.viii require greater care coordination and increased access to services within a timeframe to prevent hospital readmissions for highly complex patient populations. These populations include individuals with co-morbidities, mobility issues and transportation barriers, and poor health literacy. The availability of co-located services in one-stop clinics will greatly increase the ability of care coordinators, case managers, and community health navigators to ensure patient adherence to care plans and access to needed services. 587.2(b) prohibits outpatient programs without an operating certificate. This

Mount Sinai Hospitals Group (PPS ID:34)

#	Regulatory Relief(RR)	RR Response
		will limit the ability to open new programs through the coordination of two existing already-licensed providers. 587.5(h) limits changes in physical space, location, use of additional sites and change in capacity. These requirements should be waived to permit joint programs among already-licensed providers under PHL Article 28, or MHL 31 and/or 32. For the purpose of calculation of staffing requirements under 14 NYCRR 587.15, to allow for flexible staffing at multiple sites, staffing ratios should be consolidated to central service site. (Patient safety should not be adversely affected because staffing ratios will still be maintained at the provider, and the remote site will be co-located with another licensed provider entity.) Overall, patient safety should not be affected because the new sites involve only already-licensed operators and the applicable space will meet life safety requirements generally. Safety will likely be enhanced because of the availability of multidisciplinary services, which will improve the ability of patients to receive needed care in a timely manner.
24	14 NYCRR 588.5 (Medical Assistance Payment to Outpatient Programs)	All MSPPS selected projects will require the participation of sites with co-located services in order to seamlessly integrate services and achieve the goals of DSRIP. Specifically, the entire focus of Project 3.a.i is centered on the co-location of behavioral health and primary care services. The need for behavioral health services among the patient populations targeted in each project is pronounced, specifically the behavioral health population in Project 3.a.i and 3.a.iii, and additionally individuals with co-occuring behavioral health disorders targeted in Project 3.b.i (cardiovascular conditions), 3.c.i (diabetes), and 4.c.ii (HIV/AIDS). All projects require greater coordination of care and increased access to preventive care, which can be enhanced through co-located behavioral health, primary care, and other needed clinical services. Projects 2.b.iv and 2.b.viii require greater care coordination and increased access to services within a timeframe to prevent hospital readmissions for highly complex patient populations. These populations include individuals with co-morbidities, mobility issues and transportation barriers, and poor health literacy. The availability of co-located services in one-stop clinics will greatly increase the ability of care coordinators, case managers, and community health navigators to ensure patient adherence to care plans and access to needed services. 14 NYCRR Part 588.5 is a provision that requires, among other things, that any program should have a valid operating certificate issued by OMH. To effectively co-locate services and provide behavioral health services at a primary care site, not only must providers comply with the substantive requirements of Part 587, but they will not be paid for services unless they meet the requirements of 588. No OMH operating certificate should be required for a location whose expansion or operation is approved due to waivers pursuant to an approved DSRIP program in order for the applicable program to receive reimbursement. Patient safety should not be affected because the sites involve only already-licensed operators and the applicable space will meet life safety requirements generally. Safety will likely be enhanced because of the

Mount Sinai Hospitals Group (PPS ID:34)

#	Regulatory Relief(RR)	RR Response
		availability of multidisciplinary services, which will improve the ability of patients to receive needed care in a timely manner.
25	10 NYCRR 791.2 (Hospice Operation – General Provisions)	The goal of Project 2.b.viii is to reduce 30-day hospital readmissions for Medicaid beneficiaries discharged into home care. Through care coordination and wrapping the target patient population with all needed services, including hospice and palliative care, the project will address patients' underlying health and social service needs that drive hospital readmissions. Hospice and palliative care services that reduce patient pain and discomfort are key to better meeting the needs of this population, but are lacking within the service area. In addition, in order to integrate services across the entire service area as required by DSRIP and Project 2.a.i, hospice providers will need the flexibility to serve patients within the entire MSPPS service area. 10 NYCRR 791.2 requires a hospice to obtain approval for any change to its geographic service area. This requirement should be waived for a hospice that participates in the MSPPS, and that receives a patient referred by another MSPPS member in which the hospice and the MSPPS member are engaged in a care coordination program. Expanding the service area of already licensed providers should not adversely affect patient safety.
26	10 NYCRR 762.2 (specifically, 762.2(c))	10 NYCRR 762.2 (specifically, 762.2(c)) (Certified Home Health Agencies and Licensed Home Care Services Agencies; Approval of Home Care Programs and Program Changes) The goal of Project 2.b.viii is to reduce 30-day hospital readmissions for Medicaid beneficiaries discharged into home care. Through care coordination and wrapping the target patient population with all needed services, the project will engage home care providers to address patients' underlying health and social service needs that drive hospital readmissions through multidisciplinary teams and greater care coordination. This effort is part in parcel of the greater goal of DSRIP and Project 2.a.i to integrate services across the entire service area. To accomplish these goals, home care providers will need the flexibility to serve patients within the entire MSPPS service area. 10 NYCRR 762.2 requires a certified home health agency or a long term home health care program to obtain approval for a change in the program's geographic service area. This requirement should be waived for any agency that participates in the MSPPS, and that receives a patient referred by another MSPPS member in which the agency and the MSPPS member are engaged in a care coordination program. Expanding the service area of already licensed providers should not adversely affect patient safety.
27	10 NYCRR 599 (Clinic Treatment Programs)	All MSPPS selected projects will require the participation of sites with co-located services in order to seamlessly integrate services and achieve the goals of DSRIP. Specifically, the entire focus of Project 3.a.i is centered on the co-location of behavioral health and primary care services. The need for behavioral health services among the patient populations targeted in each project is pronounced, specifically the behavioral health population in Project 3.a.i and 3.a.iii, and additionally individuals with co-occuring behavioral health disorders targeted in Project 3.b.i (cardiovascular conditions), 3.c.i (diabetes), and 4.c.ii (HIV/AIDS). All projects require greater coordination of care and increased access to

Mount Sinai Hospitals Group (PPS ID:34)

#	Regulatory Relief(RR)	RR Response
		preventive care, which can be enhanced through co-located behavioral health, primary care, and other needed clinical services. Projects 2.b.iv and 2.b.viii require greater care coordination and increased access to services within a timeframe to prevent hospital readmissions for highly complex patient populations. These populations include individuals with co-morbidities, mobility issues and transportation barriers, and poor health literacy. The availability of co-located services in one-stop clinics will greatly increase the ability of care coordinators, case managers, and community health navigators to ensure patient adherence to care plans and access to needed services. 14 NYCRR 599.2 prohibits the operation of outpatient programs for persons with mental illness without an operating certificate issued by the commissioner of mental health. 14 NYCRR 599.5(e)(1) requires satellite operations of clinics to be approved under Part 551. 14 NYCRR 599.5(f) and (g), require OMH approval for changing hours of operation or establishment of a new program. 14 NYCRR 599.14 should be waived as to the maximum number of payable claims per day (only three Medicaid claims per day are permitted) if the services are provided at a multi-disciplinary site and consist of a mix of services. Any expansion site operating at a site approved to provide medical or health services or substance abuse services should be deemed approved under Section 551 and satisfying the applicable 599 requirements. Patient safety should not be affected because the expanded sites involve only already-licensed operators and the applicable space will meet life safety requirements generally. Safety will likely be enhanced because of the availability of multidisciplinary services, which will improve the ability of patients to receive needed care in a timely manner.

Mount Sinai Hospitals Group (PPS ID:34)

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 MSPPS includes hospitals, nursing homes, clinics, home care, and behavioral health providers, as well as social services, such as supportive housing, transportation services, and specialized meal program providers, among others. Our goal is to build a broad, clinically integrated delivery system linked to a comprehensive set of social services to support our partnership in providing whole person care.

During the planning phase, we engaged our partners through a virtual governance structure, the Project Advisory Committee (PAC). This structure was led by a Leadership Committee, which oversaw four technical committees (Clinical, IT, Workforce, and Finance) representing the continuum of care and all regions. Our Leadership Committee includes representatives from acute care; sub-acute care providers such as FQHCs, nursing homes, and behavioral health agencies; an array of home and community-based service providers; labor; and IPAs and health plans. Technical committees are complemented by borough level workgroups to raise regional concerns and address local barriers.

Mount Sinai Hospitals Group (PPS ID:34)

Partners were asked to provide nominations for the technical committees from which we made membership selections. Committee members were appointed on an interim basis during initial planning by the lead entity and with input from the PPS. We intend to affirm our appointments based on changes in our membership and service area in January 2015 through the direction of the Leadership Committee. The committees and their subgroups all included representatives from our partner organizations, as well as stakeholders impacted by our PPS (consumers, labor unions, health plans, and other community providers).

By April 1, 2015, our goal is to establish an LLC operating under a Delegated Governance structure. The LLC will provide operational and governance leadership for the MSPPS through a representative management committee (referred to throughout as the Leadership Committee). It is our intent to keep, to the extent possible, our current governance structure under the LLC and the Delegated Model. We chose this model after multiple meetings and discussion with our Leadership Committee and with input from partners through Town Halls. There was broad agreement that the Collaborative Contracting Model would be extremely workload intensive for a PPS of our size, and onerous for decision making. Our partners also agreed that there was little appetite for moving to the Fully Incorporated Model, as few were ready to lose their organizational identity. The PPS partnership agreed that the Delegated Model would be the most effective structure to stand up projects and meet DSRIP program goals, while ensuring partners had a voice in the process. For these reasons, the Delegated Model, governed through our current PAC framework was identified as the best model for our PPS to ensure that there is continued broad representation of our partners, regions, and patients.

Furthermore, there was broad acknowledgement that there exists a wide range of expertise, capabilities, and infrastructure across the PPS, particularly around clinical integration and population health management. Some participants have robust systems in place to manage patient care, others have little experience or capacity. It quickly became clear that MSPPS should establish a Project Management Office (PMO) to provide operational support and project management to ensure metrics and milestones are met. This PMO would need the support of a Management Services Organization (MSO) to provide clinical integration supports and population health management services to some of partners depending on their need. The PMO will provide organizational efficiency across the PPS to ensure alignment across providers and practices. The PMO and MSO will provide services under the direction of the lead entity and Leadership Committee.

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.

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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 LLC's Leadership Committee will be responsible for identifying and creating a structure for collaborative dialogue across our committees and borough workgroups so that decisions are made through a collective and transparent process and that deliverables are met. The Leadership Committee is charged with overseeing technical committees and borough workgroups to ensure that proper planning, governance, and oversight is occurring and that the PPS is successful in meeting outcome goals. For more information about the makeup of the Leadership Committee, please see the prior question.

In addition to its oversight and guidance role, the Leadership Committee is also responsible for:
-Monitoring performance of the PPS, including the work of committees, partners, and vendors
-Approval of committee charters, policies, and procedures
-Approval of DSRIP reporting to the state and CMS
-Approval of contracts and agreements for the PPS
-Development and approval of partnership and data sharing agreements
-Development and approval of a dispute resolution process

Mount Sinai Hospitals Group (PPS ID:34)

Technical committees will be led by members of the Leadership Committee or their designee. The Clinical Committee is responsible for sharing best practices and innovations, developing clinical protocols and processes, and instilling clinical excellence into implementation planning. The IT Committee will work to establish guidelines and protocols on data sharing and usage to support population health, while the Workforce Committee is charged with overseeing and advising on workforce planning and redesign. Finance Committee is responsible for establishing an approach to distribution of DSRIP funds among partners. Each committee is co-chaired by a representative from the lead entity and at least one (and some cases two) representatives from a partner entity, depending on the size of the committee. Key leadership positions are spread to represent all industry sectors. All committees have been populated with standing members representing PPS partners who participate and support the work of the committee, who are joined by participants that include partners and stakeholders who want to observe and provide feedback to the committee on an ad-hoc basis. This structure was designed to accommodate organizations who do not wish to be a standing member, but have an interest in the work of the committee.

Our PPS will invite partners to identify individuals within their organizations to participate in borough level work. We recognize not all partners will have the staffing to participate in each committee and workgroup. As such, we will continue to make meeting materials available online and provide opportunities for feedback in person, by phone, and email, as we do for our committee development today.

Technical committees are responsible for developing standardized approaches, while borough workgroups implement the approaches developed. It is also a vehicle for addressing regional differences impacting implementation and facilitating stakeholder feedback. These workgroups also allow local implementation issues to be raised and addressed. Any implementation issues that are not addressed at the workgroup level will be elevated to the appropriate technical committee. If they are not resolved at the technical committee, the issue will be brought to Leadership. We believe this will create a uniform approach in developing project goals and implementation approaches across the PPS, while providing opportunity for regional variation. Borough workgroups, to the extent possible, will hold local meetings, as well as online webinars, to provide as many opportunities for participation as possible. Each PPS partner will be invited to identify individuals within their organizations to participate in regional subcommittees under the borough workgroups to translate the PPS high-level work at the regional level.

***Structure 3:**

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

The Clinical Committee will oversee DSRIP implementation by providing feedback on best practices and innovative strategies, development of clinical protocols, and ongoing evaluation of outcomes. It is comprised of clinical leaders from across the PPS representing a range of provider types and geographical areas. Currently, there are more than 70 individuals on the Clinical Committee representing more than 45 organizations. Of these, there is an average of 50 individuals who regularly participate in the committee. These representatives were nominated by their peers or requested to participate. We anticipate as we move forward with implementation this make-up will shift to accommodate our providers who are actively participating on projects, particularly those participating on multiple projects.

Fundamentally, the Clinical Committee is responsible for establishing overall care delivery standards to meet metrics and milestones and informing clinical redesign and care coordination strategies. The committee will develop standardized care approaches, and support the development of borough-level workgroups. As such, the committee will be able to solicit feedback and address regional differences impacting implementation. Information from the boroughs will be passed up to the Clinical Committee. If a challenge or issue that reaches beyond the expertise of the Clinical Committee arises, it will then be directed to the Leadership Committee for review and consideration. The committee will also inform process and outcome goals by provider type based on the selected DSRIP projects to inform the development of performance-based agreements in coordination with Finance Committee.

***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 MSPPS intends to provide support to partners to facilitate their participation in a future Medicaid risk-bearing entity and in risk contracts. The PPS will provide critical MSO supports and services to its partners and track the establishment of ACO and other regulations impacting risk-bearing entities. Once the PPS partners are ready to bear risk, we will establish a separate risk-bearing entity to establish reserves as needed. While our goal is to maintain our current committee structure to the extent possible, it is likely that reserve

Mount Sinai Hospitals Group (PPS ID:34)

requirements will require establishing equity partners.

In that event, we would create an Executive Board comprised of equity and non-equity shareholders. Non-equity partners from the LLC's Leadership Committee will still participate in the governance structure of the new entity. It is our intent to ensure that all partners have a voice through this transition and to preserve as much of the LLC's current governance structure as feasible. Our approach of first establishing an LLC and then transitioning to a risk-bearing entity will allow us to establish our PPS quickly in a transparent way and provide time to evaluate ACO rules and engage in dialogue and build trust with partners to ensure the MSPPS is ready and willing to participate in risk-sharing payment models.

Our approach will enable the PPS to transform into a highly performing organization by ensuring broad and fair representation across the continuum of PPS providers, while allowing the PPS to move quickly and nimbly in making decisions. Ultimately, our goal is to create a sound organizational structure that allows the PPS and our partners to effectively manage population health and take risk, thereby realigning financial incentives, increasing efficiency, and improving access to primary, outpatient, and preventive care for Medicaid patients in our service area.

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.

Our governing body includes a Leadership Committee, driving the work of PPS-wide technical committees (Clinical, Workforce, IT, and Finance). These technical committees develop standards and approaches applied PPS-wide to inform the detailed work of implementation.

Our Leadership Committee is led by three co-chairs: Arthur Gianelli, President of Mount Sinai St. Luke's (representing the Mount Sinai Health System and hospitals), Mali Trilla, CEO of Settlement Health (representing FQHCs and primary care), and a recently vacated seat held by VNSNY (representing home care and care transitions). Co-chairs provide leadership and management of 25 committee members representing behavioral health, developmental disability, long-term care, and community-based providers. Our ex-officio seats include two plan representatives, two external IPA representatives, and one Bronx Lebanon PPS representative, our strategic partner in the Bronx. These representatives provide insight on issues related to payment reform and advise on collaborating with other PPSs.

Our approach is to have representation across the continuum of care and regionally at each governance level.

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

To populate key governance roles, the MSPPS first established the types of representatives it desired to populate the Leadership Committee and technical committees. We intend to maintain this structure and democratic process as we develop a formal governing body.

As the lead entity, Mount Sinai put forth a co-chair for the Leadership Committee to work with a co-chair representing primary care providers. Together, these two co-chairs are responsible for ensuring the PPS Leadership Committee formalizes a governing charter, adheres to the standards and objectives defined within the charter, and carries out the collective vision of the PPS as related to DSRIP project planning and selection over the course of the first demonstration year.

Through a PPS-wide committee nomination process facilitated through an online survey sent to the PPS, partners submitted technical committee nominations. Candidates were selected based on expertise, regional representation and the identified key representational roles by provider type, geography, union status, and stakeholder interest. This included representatives by facility or specialty type, for example behavioral health, nursing homes, FQHCs, primary care physicians, health plans, community members, labor unions, Health Homes, and home care. To further round out representation, we reached out to community leaders and peers to seek their feedback on

Mount Sinai Hospitals Group (PPS ID:34)

candidates.

Committee members were critical in political discussions and helped to guide the work of the IT, Finance and Clinical Committees. Members discussed and voted on key decisions. Each member was allowed to vote once and members had to be actively participating in the meeting to place their vote. Ex-officio members were not allowed to vote, but they were still encouraged to participate in discussions prior to the committee holding a vote.

Members were encouraged to remain in their position throughout the duration of the planning process and application submission. However, adjustments were made as needed and to ensure appropriate representation of our network of partners.

Following the finalization of the PPS network, a formal process to elect governing members will be based on the same procedure used to establishment of our PAC in July 2014, including:
-A review of the network by provider type, attributed lives, and regional representation;
-A nomination process whereby partners submit nominees for governing committees; and
-An extensive vetting process that takes into account the capacity, experience, specialties, and competencies.

***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.

Partners are engaged and encouraged to participate at all levels of our organizational structure, including CBOs. MSPPS takes stakeholder input seriously and believes DSRIP is fundamentally a trust-building exercise that is critical to ensure that partners can take value-based contracts together. Each partner organization had the opportunity to nominate and/or self-select representatives to committees. We also solicit feedback from the community on who would best represent our service area.

While we have limited membership on each committee to ensure that all partners have an opportunity to participate and be reflected in the governance structure, we encourage non-members to engage as "participants" in these meetings and provide feedback and input. Moreover, we have taken significant steps to vet and ensure that each committee has representatives willing to be active participants and that the continuum of care and service area is reflected in the makeup of the committee members.

***Process 4:**

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

Our partners and community stakeholders are actively engaged through myriad of communication avenues, including our PPS email, website, newsletter, and public meetings. We seek their input on major items, including input on CNA development and results, and actively encourage questions at meetings through multiple Q&A sessions. CBOs are key partners in our PPS development and we value their participation, including that of the AIDS Service Center and Little Sisters of the Assumption Family Health Services, on our Leadership Committee.

Our funds flow allocates 5% to non-safety net providers, including CBOs. Initially it is likely that CBO services will be partially funded through grants and PPS contracts to build upon current sources of CBO revenue. We anticipate an incremental expansion of CBO services within managed care contracts. Ultimately, integrating CBOs into core care pathways will demonstrate their value to medical providers and managed care organizations.

***Process 5:**

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

The purpose of the committees and workgroups is to develop and implement DSRIP projects in a team setting for MSPPS. Each committee is currently co-chaired by a PPS partner stakeholder and a Mount Sinai Health System executive. This structure will continue in the formal governing body. The goal of these committees is to create an atmosphere of trust and cooperation and find a shared vision on planning standards, participating provider criteria, and project decisions.

Each committee and workgroup member is provided with a committee charter that outlines expected conduct, as well as roles and responsibilities. These charters were developed collaboratively by members. In addition, committee members established decision making

Mount Sinai Hospitals Group (PPS ID:34)

processes and policies to build agreement on planning and implementation action items. Each committee is facilitated by PMO staff and is encouraged to have open and respectful discourse in which all voices are heard. All views expressed are considered and decisions are made on a consensus basis. Any concerns are duly noted and discussed.

When committees are asked to adopt key decisions, a formal discussion and debate is undertaken in which all perspectives are considered, noted, and documented. For key decisions, committees hold votes during committee wide meetings. If the committee deems an inadequate number of members are available to make the vote then, depending on the urgency of the issue, the vote is either held at the following meeting, or distributed by survey via email to the full committee. This process is consistent across all committees.

***Process 6:**

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

All governing decisions are consensus driven. Core values of transparency, open discourse, trust building, and dispute resolution are critical components of the decision making process. While committees and workgroups strive to build consensus, when disputes occur, committee co-chairs and members work with their PMO staffing support to address concerns raised. Any disputes that cannot be resolved at the committee-level are escalated to the Leadership Committee for review and consideration. If needed, issues can be brought back to the committee, workgroup, or entire governing structure for broader discussion among all participants. Should a resolution fail to attain consensus at the leadership level, issues are then escalated to Mount Sinai Health System (Mount Sinai) for resolution, as the lead entity and fiduciary for the PPS. If needed, Mount Sinai Health System leaders will consult with the state for further guidance that may support decision-making.

***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.

MSPPS has demonstrated a keen understanding of the critical importance of transparency and communications from the beginning. Through our website, weekly newsletter, and biweekly Town Halls, we distribute news, committee materials and minutes, and meeting audio and video, and other key information to ensure our partners are informed of the decisions made by the PPS. We regularly disseminate fact sheets and decision guides designed to engage and inform partners and stakeholders. Our commitment to transparency is also demonstrated by our early release of design grant and DSRIP application drafts to solicit community and partner feedback. That feedback is taken seriously and incorporated into final submissions.

All of our PPS meetings are open to the public and any partner or community member is welcome to attend committee meetings and Town Halls. We post meeting times and locations on our website, as well as provide either phone or webinar dial-in options for remote attendees.

***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.

MSPPS understands the importance of stakeholder feedback and developed a comprehensive and transparent stakeholder engagement plan. Our approach ensures that community voices, including those of the patients we are serving, are respected and heard so that we receive the broadest set of input. We engage with local residents in discussions about DSRIP and community needs by presenting at community board meetings. Our lead entity has community boards, which are networks of affiliates, alliances, and partnerships with governing bodies, schools, religious institutions, social agencies, and neighbors themselves, which are associated with each of their local hospitals. MSPPS presented on upcoming DSRIP changes at their regular meetings where community leads, residents, and executives of CBOs were in attendance and will continue this engagement. Our key partners also serve as liaisons to the community, facilitating borough level meetings with stakeholders and filtering up consumer input.

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:

Mount Sinai Hospitals Group (PPS ID:34)

***Committee 1:**

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

The MSPPS PAC structure, which encompasses our governance structure of all committees and technical committees, was established in May and committee member nominations were initiated in June. The first committee meetings were held in September. When established, MSPPS represented more than 5,000 providers from 175 parent organizations, with a service area of all five boroughs in New York City and Westchester County. The structure and member nomination process developed by the PPS Lead was designed to ensure broad partner representation across counties, provider types, and stakeholder interests. This inclusive and collaborative approach promoted transparency and the cross-pollination of ideas and perspectives throughout DSRIP planning.

Comprised of 25 members, the Leadership Committee was established to enable effective governance and oversee the PAC. Members were nominated to ensure a cross-section of geography and providers by type, as well as core competencies, including financial, clinical, and workforce expertise. Membership was also determined by the number of Medicaid lives served by organization and strategic alignment to key DSRIP goals - systems integration, population health, and managed care.

A PPS-wide committee nomination process was held in July via survey and members were selected based on their expertise, provider type, and organizational competencies.
Clinical, Finance, IT, and Workforce Committees were established with 30-50 members representing multiple organizations and geographies. These technical committees were formed in alignment with the key areas critical to the PPS's success. For example, the Clinical Committee was responsible for instilling clinical excellence into project planning, while the IT Committee was charged with assessing technology needs and establishing guidelines on data sharing. Subgroups were formed under these committees to leverage the expertise of PAC members with specialized knowledge. Clinical subgroups include Integrated Delivery System Development, Care Transitions and Home Care, Behavioral Health, and Disease Prevention and Management, while IT subgroups are comprised of Health IT Architecture, Network Development, and Minimum Data Sets. All technical committee meetings were open to all PPS members and the public with in-person meeting locations and call-in numbers posted on the PPS website.

***Committee 2:**

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

The role of the PAC was presented to the PPS at the June 5 Town Hall. Charters defining committee roles and responsibilities, as related to the completion of the DSRIP application, were created jointly with committee members and posted on the website. Committees and subgroups were charged with a number of duties, including informing clinical strategies, developing criteria for network participation, developing a budget for the project plan, long-term sustainability planning, assessing IT capabilities and solutions for data sharing, and reviewing the Project Plan. Meetings were held on a weekly or bi-weekly basis and all members were expected to participate. Committee and subgroup co-chairs had weekly calls to develop meeting agendas, discuss state DSRIP updates, and identify data needs. Content and expertise was shared across committees and to the entire PAC at Town Halls. Our proposed governance entity will come from the PAC structure as it currently exists.

***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).

From the start, PAC members have played a key role in the development of both the current PPS organizational structure and the future governing entity. Committee members developed committee charters outlining roles and responsibilities collaboratively and assigned subgroup members to specific tasks. The Leadership Committee debated and vetted several governance model options and ultimately voted on the Delegated Model described in this section.

The PAC was also engaged in the development of the CNA through various means. At the August 14 Town Hall, small breakout groups brainstormed areas where additional data was needed, for example housing need and the reentry population. These suggestions were posted on the website, distributed through the newsletter, and incorporated into the provider CNA survey, which was completed by nearly all partners. Top line CNA results were shared with committee members and the PPS at large, who recommended additional data to be included in the final CNA.

***Committee 4:**

Please explain how the selected members provide sufficient representation with respect to all of the providers and community organizations

Mount Sinai Hospitals Group (PPS ID:34)

included within the PPS network.

Committees were populated by nominations received from interested providers from across the service area and by members of Mount Sinai leadership. To ensure each committee represented the cross-section of provider types and geographies across the service area, committees were populated by project team members. On the Finance Committee there q43 about 30 members and attendance at meetings is upwards of 25. IT Committee has more than 20 members with 90% participating in committee meetings. Both of these committees were divided into subgroups to focus on select issues and each subgroup holds regular meetings. IT subgroups have about 10 people on each and Finance subgroups have an average of 15 members. Workforce Committee has about 50 members and participants, of which more than 30 attend meetings regularly. Clinical Committee membership is detailed earlier in this section. Each committee was designated a set of co-chairs, consisting of a Mount Sinai executive and partner executive.

Section 2.4 – Compliance:

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

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

A designated compliance officer will be hired from outside the PPS and have no direct ties in order to maintain integrity of the compliance process. The compliance officer will have autonomy in investigating compliance complaints to ensure minimal influence from PPS partners that can impact an investigation. MSPPS will create a reporting structure where the compliance officer is able to report freely and openly with the lead entity and PPS leadership about any and all compliance issues. The MSPPS will create a shared understanding that the main goal of the compliance officer is to protect the patient from harm and the PPS from bad actors. The compliance officer will ensure proper adherence to state and CMS requirements. He or she will work under the direction of the lead entity and Leadership Committee to ensure regulatory compliance, as well as support the PMO and MSO in performance management of DSRIP projects.

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

In consultation with state and federal regulators, the MSPPS will establish necessary compliance measures to ensure that partners are performing well and that patient care and safety are prioritized. Specific metrics will be tied to each measure to provide clear and consistent understanding, practice, and enforcement. The compliance officer will work closely with project managers to identify on-the-ground issues and provide guidance as needed to assist partners in complying with state and federal regulations.

The compliance officer will also monitor partner achievement of performance goals through quarterly reporting. The officer will conduct internal unannounced audits of PPS compliance practices. The PPS may hire an outside vendor to conduct audits. Audit findings will be validated and reviewed longitudinally to ensure that smaller issues do not continue over time. Changes to the mechanisms for identifying and addressing compliance will be made to maintain patient safety as needed.

***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.

MSPPS will have a yearly compliance training for all PPS members and coalition partners. Compliance training will entail an in-person review of state and federal requirements that pertain to DSRIP and other related programs. Standardized materials will be created with established training entities and updated as necessary. Any major changes will be communicated to PPS members and coalition partners on an ad hoc basis. The training will consist of presentations, speakers, videos, printed materials, and working group activities. The working groups may be required to present to those at the training or role play within their smaller group. Those who participate in this training will be required to meet a specific understanding of state and federal rules and regulations as determined by state, federal, and PPS leadership to ensure that patient safety is never at risk during the transition into an integrated health care delivery system.

For partners who have existing yearly compliance training, and who would like to integrate DSRIP compliance training into their curriculum, the DSRIP PMO will work with their HR and compliance program managers to support this inclusion.

Mount Sinai Hospitals Group (PPS ID:34)

***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.

The PPS will establish a compliance complaint process that will be communicated to beneficiaries and uninsured community members through community board meetings, open public meetings, and borough specific events. The compliance complaint process will also be published on the PPS website and there will be a dedicated email account for individuals to report compliance concerns and issues. Interested parties will be able to request a mailed hard copy of the process and if necessary, a dedicated phone line and number will be created. This complaint process will consist of the specific compliance requirements that the PPS must abide by and a form for completion, as well as a detailed, step-by-step process to file a complaint. A response will be provided to the complaining party promptly with a detailed timeline as to what next steps are available to the complaining party.

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.

Our governance structure incorporates a comprehensive set of processes to support the financial health of the PPS. Working with the Leadership Committee and the Compliance Officer, the Finance Committee will:
- Develop and approve policies and procedures for funds flow;
- Establish mechanisms for financial accountability, audit controls, and oversight for management of DSRIP funds;
- Bring material exceptions, questions, issues, and variances to budget to the attention of the Leadership Committee;
- Monitor financial performance of the MSPPS and all partners and report regularly to the Leadership Committee, including pro-active review and request for disclosure of key financial indicators and activities that may impact partner or PPS sustainability and performance;
- Review and approve annual MSPPS operating and capital budgets, including at least annual evaluation of DSRIP funds flow to optimize performance and ROI; and
- Coordinate with the Leadership Committee, technical committees, and health plans, to support partners as they transition from the fee for service system to a value-based payment system.

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

Key finance functions of the PPS are assumed by the Finance Committee, which will have principle accountability for and oversight of all financial matters for the MSPPS. The Finance Committee will work with the Leadership Committee to further develop and implement the financial policies and procedures to be used by the PPS, including but not limited to:
- Completing the design and implementation of DSRIP funds distribution model;
- Informing development of partner performance-based contracts;
- Developing criteria and standards for partner share of DSRIP funds;
- Defining the financial performance metrics that partner organizations are expected to meet;
- Establishing an annual budget;
- Launching financial compliance program in conjunction with the Compliance Officer and the Leadership Committee;
- Developing an annual audit and oversight process and controls for DSRIP funds; and
- Developing an ongoing partner assessment process and dashboard to monitor performance and to proactively elicit partner information to ensure early awareness of potential risks.

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

In addition to the Compliance Officer's internal monitoring and auditing of PPS activities, MSPPS may hire an outside vendor to conduct audits. The Leadership Committee will coordinate with the Finance Committee and the Compliance Officer to identify an appropriate audit firm(s) for MSPPS oversight. As appropriate, an RFP may be issued to select a qualified external auditor, and any contract will be reviewed annually. Should a separate contract be required for a general compliance auditor, the RFP and selection for this will be

Mount Sinai Hospitals Group (PPS ID:34)

undertaken by the Finance Committee in coordination with the Leadership Committee, Chief Financial Officer of Mount Sinai Health System, and Compliance Officer. When complete, the MSPPS compliance program will meet all requirements of New York State Social Services Law 363-d.

***Organization 4:**

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

Building on the compliance experience of Mount Sinai Health System and other MSPPS partners, an Audit Committee and Finance Committee will meet in a joint work group facilitated by the Compliance Officer in order to draft a compliance program for the review and approval of the Compliance Officer and the Leadership Committee. This comprehensive compliance program and associated disciplinary policies will be consistent with the requirements under the New York State Social Services Law 363-d including, but not limited to regular compliance training; multiple communication methods to report compliance issues; policies encouraging reporting; discipline procedures for failure to report and prohibiting retaliation; and ongoing identification and correction of risk areas. We will have a written code of conduct that applies to all PAC members, which will be provided upon appointment and re-enforced annually as part of our compliance training program. As noted, we will offer an anonymous method to report potential compliance issues, and consistently emphasize our non-intimidation and non-retaliation policy.

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.

Partner provider performance will be monitored across a series of standard indicators (e.g., clinical, financial, quality, and process measures), with PPS-wide core indicators and provider-type specific indicators to effectively evaluate ongoing performance towards DSRIP metrics and milestones, as well as PPS-wide population health standards as defined within partner agreements and set by respective committees. Partners will commit to meeting these standards as part of the partner agreements. Data and key indicators will be organized in a dashboard format for review by the MSPPS project staff, then by technical committees, and followed by the Leadership Committee. Over time, thresholds will be set based on prior historical performance and peer/industry benchmarks to ensure optimal performance and ongoing improvement. The Finance Committee will be responsible for monitoring overall DSRIP performance as defined in the Domain 1 metrics and milestones and partner agreements, ensuring DSRIP fund distributions correlate with performance and meeting defined expectations. Financial incentives will be put into place to encourage top performance.

***Oversight 2:**

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

The oversight of PPS partner performance must balance: 1) strong accountability to individual and PPS performance; 2) the need to provide structure, guidance, and support to more resource-challenged PPS providers; 3) the importance of data driven "dashboard" metrics and benchmarking; and 4) the need to incorporate feedback from Medicaid beneficiaries.

MSPPS will establish clear contractual expectations based on standard, consensus-based performance metrics with consequences for continued poor performance and a standardized appeal procedure. Performance data will be transparently reviewed on a regular basis so that poorly performing providers will have early indications and interventions when performance has begun to suffer or appears at risk. These providers will be placed on a Corrective Action Plan (CAP) with support provided by the PPS as appropriate. Depending on the deficiency (e.g. IT adoption, financial health, or clinical performance), a sub-committee of the Technical Committee (s)will be appointed by the respective co-chairs to support CAP implementation and to report to the Leadership Committee on progress and/or continued under-performance.

***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.

Mount Sinai Hospitals Group (PPS ID:34)

As discussed above, poorly performing partners will be given opportunities to seek help and take corrective action. Providers on a CAP who are either unable to engage in performance improvement activities to change performance and/or are unwilling to do so will undergo a process of peer review overseen by the Clinical and Leadership Committees in coordination with the assigned the Compliance Officer. After a prescribed amount of time and set of attempted interventions as per the policies and procedures of MSPPS (which will be compliant with the standard terms and conditions of the waiver), the Clinical Committee and Compliance Officer will make a recommendation to the Leadership Committee to remove the poorly performing member.

***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 incorporate into its own policies and procedures existing complaint and appeal processes for Medicaid beneficiaries. This process will create a formal avenue for patient concerns regarding provider dissatisfaction, appointment scheduling, and denied referrals, as well as other issues. Mechanisms to support this may include a PPS Ombudsman Office with a dedicated email and call-in line. The Ombudsman will engage with the Medicaid population by attending community board meetings and working closely with community advocates and the state. Patient concerns will be raised with providers and, if there is a pattern of issues, will be included in lower performing providers' CAPs. While CAPs will provide a critical focus on improving performance over time, it is essential that there is accountability to the entire PPS for continuing failure to improve performance by removing members after a reasonable period.

***Oversight 5:**

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

Pending the state issuing regulatory relief on HIE consent, it is unlikely that the PPS will have the legal authority to notify Medicaid beneficiaries if their PPS provider is removed from the PPS per MSPPS policies and procedures. However, the PPS Ombudsman will work closely with Medicaid advocates and providers to ensure that this information is shared and to the extent possible, that Medicaid beneficiaries receive advance notice of an action to remove their provider from the PPS. To the extent possible, information will be provided on how removal of a provider may impact Medicaid members and their options for seeking ongoing care if there is a risk that ongoing care may not be available with the removed provider.

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

Mount Sinai Hospitals Group (PPS ID:34)

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

Mount Sinai Hospitals Group (PPS ID:34)

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 MSPPS CNA was conducted by COPE Health Solutions, in collaboration with Harbage Consulting, from June to Dec 2014. The methodology included both qualitative and quantitative data to identify the health status, disparities, resource gaps, and clinical needs of the communities within our service area as designated in our Design Grant (NYC and Westchester Co.). In addition, data encompass the service area of our strategic partner, Bronx Lebanon PPS. Note that aggregate CNA data align with the service area of our network of providers, rather than the final narrowed service area issued by DOH on Dec 18.

Using public data sources, quantitative data was gathered for about 500 indicators based on state CNA guidance and alignment with DSRIP metrics and milestones. Indicators fell under the following categories: demographics, mortality, hospitalizations, barriers to accessing health care, health care resources, and community resources. The analysis of public sources was supplemented with survey data and a review of available literature, including existing state-required hospital CNAs.

To ensure full transparency, partners and the public had opportunities to provide input and feedback. Through surveying and community meetings, we were able to derive a rich qualitative dataset from our provider network and stakeholders. Electronic surveys were sent to all providers through email and at public meetings. This 62 question survey asked providers to identify key community health needs and barriers to accessing care. Of the approximately 200 organizations in MSPPS, 190 submitted a survey. These survey results validated quantitative data findings and captured critical information on provider readiness and gaps in care.

Initial results from the CNA were distributed in October to PAC members for review and shared with partners at a Town Hall. Feedback from the public comment period included requests for the inclusion of specific datasets, which initiated additional research.

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

Quantitative CNA data was collected from more than 100 secondary sources, including, but not limited to:
-U.S. Census
-American Community Survey
-SPARCS
-Epiquery
-NYS DOH Salient DSRIP Dashboards
-NYS DOH Hospital, Nursing Home, and Home Health and Hospice Profiles
-HRSA Site Directory
-New York State Doctor Profile

Mount Sinai Hospitals Group (PPS ID:34)

-HITE
-Medicaid Managed Care Enrollment Reports
-NYS Vital Statistics
-NYS Prevention Agenda
-NYS Minority Health Surveillance Report
-NYS Community Health Indicator Reports
-NYS DOH Performance Chartbooks
-PQI Benchmark Data Tables, Agency for Healthcare Research and Quality
-HEDIS
-NYS Kids' Well-being Indicators Clearinghouse
-Kaiser Family Foundation database

To the extent possible, data sources with statewide, borough, and county-level data were used. The analysis of these public data sources was supplemented with a review of available literature and surveys submitted by providers. The population examined in the CNA is primarily Medicaid, as these patients are the focus of DSRIP and account for roughly 40% of the population within the service area analyzed in the CNA. However, where applicable and when it was sometimes the only data available, data on all-payer data were also included.

Primary data sources through a comprehensive PPS provider survey comprised of 62 questions and submitted to approximately 200 PPS organizations. Survey results elicited critical data identifying key community health needs for the Medicaid population and barriers to accessing care. Of the approximately 200 organizations in MSPPS, 190 submitted a survey. These survey results validated our analyses of the quantitative data and captured critical information on provider readiness and gaps in care.

Qualitative data and feedback were collected through a variety of means, including electronic surveys of providers and community members, a PPS Town Hall breakout group brainstorm session, and hospital Community Board meeting discussions.

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	96	12
2	Ambulatory surgical centers	222	67
3	Urgent care centers	128	15
4	Health Homes	12	5
5	Federally qualified health centers	422	20
6	Primary care providers including private, clinics, hospital based including residency programs	14893	2865
7	Specialty medical providers including private, clinics, hospital based including residency programs	43000	8280
8	Dental providers including public and private	734	96
9	Rehabilitative services including physical therapy, occupational therapy, and speech therapy, inpatient and community based	1081	39
10	Behavioral health resources (including future 1915i providers)	242	158

Mount Sinai Hospitals Group (PPS ID:34)

#	Provider Type	Number of Providers (Community)	Number of Providers (PPS Network)
11	Specialty medical programs such as eating disorders program, autism spectrum early	91	13
12	diagnosis/early intervention	0	0
13	Skilled nursing homes, assisted living facilities	314	87
14	Home care services	654	135
15	Laboratory and radiology services including home care and community access	0	0
16	Specialty developmental disability services	392	35
17	Specialty services providers such as vision care and DME	400	3
18	Pharmacies	2208	15
19	Local Health Departments	2	2
20	Managed care organizations	7	1
21	Foster Children Agencies	6	1
22	Area Health Education Centers (AHECs)	3	2

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

***Infrastructure 2:**

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

Although the service area analyzed in the CNA is a dense environment with many health care providers and community-based resources, Medicaid beneficiaries are not always able to easily access the services they need in their local communities. Even within the state-defined MSPPS service area (Manhattan, Brooklyn, and Queens), the provider mix is weighted towards institutional resources, particularly hospital beds and inpatient settings. Additionally, many resources are located in geographic areas with higher socioeconomic status.

Finding physicians is a major challenge. While most physicians are located in Manhattan, just 40% accept Medicaid. Of PPS providers surveyed for the CNA, just one in five agreed that Medicaid patients could see a primary care provider within seven days of being discharged. In addition, there are many health professional shortage areas throughout the service area analyzed in the CNA, particularly for primary care, mental health, and dental services. The need for increased access to dental services is particularly acute.

These shortages indicate that the current provider composition should be modified to increase the number and accessibility primary care providers and preventive services. The reallocation of resources towards more outpatient and ambulatory care for primary and specialty services that can help prevent admissions and readmissions and the modification of provider sites to allow for the co-location of multiple services (e.g., primary care, behavioral health, and dental) will be critical.

Data indicate that the current makeup of behavioral health providers is also in need of a shift, both geographically and toward community and outpatient settings. Most behavioral health dollars are spent on clinical care and inpatient stays. The provider mix needs to be modified to increase access to and use of mental health and substance abuse services at primary care and community settings. In addition, regulatory and funding streams need to be modified so that they robustly recognize that critical social services are an integral treatment modality for populations with behavioral health conditions, as opposed to a "support".

Although there are a large number of home care agencies and nursing homes in the CNA service area analyzed, there is a pronounced lack of hospice and palliative care programs, suggesting a greater need for expansion and integration of these services to ensure that patients are supported through care transitions and adhere to treatment regimens following hospitalizations or stays in nursing facilities.

Overall, MSPPS needs to increase access to healthcare services in underserved areas, particularly those that also have lower socioeconomic status. Resources should be reallocated to provide more access to primary and specialty care in outpatient and ambulatory settings. Additionally, the system needs more support with care transitions and care management to ensure that beneficiaries can navigate the health care system and reach the providers that are available.

Mount Sinai Hospitals Group (PPS ID:34)

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	328	245
2	Food banks, community gardens, farmer's markets	286	0
3	Clothing, furniture banks	113	0
4	Specialty educational programs for special needs children (children with intellectual or developmental disabilities or behavioral challenges)	187	27
5	Community outreach agencies	200	7
6	Transportation services	46	0
7	Religious service organizations	41	0
8	Not for profit health and welfare agencies	92	0
9	Specialty community-based and clinical services for individuals with intellectual or developmental disabilities	210	63
10	Peer and Family Mental Health Advocacy Organizations	26	4
11	Self-advocacy and family support organizations and programs for individuals with disabilities	329	0
12	Youth development programs	881	5
13	Libraries with open access computers	200	0
14	Community service organizations	231	7
15	Education	657	1
16	Local public health programs	224	1
17	Local governmental social service programs	109	1
18	Community based health education programs including for health professions/students	207	1
19	Family Support and training	200	0
20	NAMI	6	0
21	Individual Employment Support Services	236	13
22	Peer Supports (Recovery Coaches)	10	8
23	Alternatives to Incarceration	27	3
24	Ryan White Programs	348	19
25	HIV Prevention/Outreach and Social Service Programs	232	19

***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.

One benefit of the MSPPS service area being a dense urban area is having many community-based resources. Although there is always room for improvement, there are many employment, counseling, criminal justice, legal, and other social services available to the Medicaid population.

Mount Sinai Hospitals Group (PPS ID:34)

One way these community resources need to be modified is to make resources more widely available on a geographic basis, and to ensure that Medicaid beneficiaries know how to access these vital community resources to supplement the medical care they receive. Some boroughs have significantly more resources available to the population than others. Data from Greater New York Hospital Association's Health Information Tool for Empowerment, which collects data on health and social services that serve the Medicaid and uninsured populations, show that Brooklyn offers more community-based disability, counseling, housing, food banks, and harm reduction services than Manhattan and Queens. Community navigators should be mobilized to ensure that Medicaid beneficiaries are not only aware that these community-based resources exist, but are able to access and benefit from them.

Another community resource need is transportation. Current programs used for patient transportation are unpredictable and unreliable, creating timeliness issues. Individuals must go through in-person interviews to qualify, which also creates administrative hurdles. Increasing reliable transportation services for vulnerable population can also ensure access to services that are limited in certain counties.

Access to healthy, nutritious food is a key need in the service area. While there are a number of food pantries and food banks, more could be done to increase not just access to healthy food but more awareness about the importance of good nutrition for good health and the skills to prepare healthy food on a budget. Contributing to this is a lack of access to safe places to exercise.

The MSPPS service area could also use increased access to safe, stable, and affordable housing. Poor living conditions, including exposure to mold, lead, and vermin, can contribute to poor health outcomes. Providers surveyed for the CNA were asked whether or not their Medicaid patients usually have stable housing and 49% reported that their patients do not have stable housing.

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 service area analyzed in the CNA encompasses a population of approximately 8.5 million, which represents 43% of the New York State (NYS) population. Of this total population, 70% is comprised of working age adults between the ages of 18 and 64, approximately one fifth (22%) are children, and 12% are aged 65 or older.

Of the three boroughs in the state-defined MSPPS service area, Manhattan has the smallest percentage of children (15%) and the greatest proportion of senior citizens (14%). Queens has a larger percentage of children than Manhattan (21%) and a similar percentage of seniors (13%), while Brooklyn has the greatest percentage of children (23%) of the three boroughs, with seniors only representing 12% of Brooklyn residents.

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

Of the boroughs within the state-defined MSPPS service area, Brooklyn and Queens are more diverse than Manhattan and the state as a whole. One in five (20%) Brooklyn residents are Hispanic, 35% are African American, 36% are white, and 12% are Asian, while 38% are foreign-born. In Queens, Hispanics comprise the largest proportion of the population (28%), followed by whites (27%), Asians (25%), and African Americans (21%), while nearly half are foreign-born. In NYC, 49% of residents speak a language, half whom speak Spanish (25%).

Low health literacy has a number of negative health outcomes, including higher rates of hospitalization. According to nationally averaged data, 41% of African Americans, 24% of Hispanics, and 30% of Medicaid beneficiaries living in poverty scored "below basic" in a health literacy survey. Neighborhoods in Manhattan, Brooklyn, and Queens with high levels of poverty and large African American and Hispanic populations are likely to have low health literacy.

***Demographics 3:**
Income levels:

Mount Sinai Hospitals Group (PPS ID:34)

The median household income in NYC is $51,865, about $6,000 lower than the statewide median income of $57,683. Manhattan has the highest median income of the three boroughs in the state-defined MSPPS service area at $68,370, followed by Queens ($56,780), and Brooklyn ($45,215). Throughout these boroughs there is great disparity in median income levels. For example, in Manhattan the median annual income at the Census tract level ranges from a high of $243,622 to a low of $11,270.

There is also disparity in median income by race/ethnicity throughout the boroughs. In Brooklyn, the median income for white households is $61,483, compared to $36,730 for Hispanic households. In Manhattan, the disparity between white and Hispanic incomes is far more pronounced. The Manhattan household median income ($107,436) is more than three times that of Hispanic households ($32,401). In Queens, the income gap between whites and Hispanics is less striking, at $61,902 and $50,072 respectively.

***Demographics 4:**

Poverty levels:

One in five residents (20%) in the service area analyzed in the CNA live below the federal poverty line (FPL). Nearly a quarter (23%) of Brooklyn residents live below the FPL. Queens has 14% of residents living below the FPL, and 18% of Manhattan residents live below FPL. Pockets of high poverty in Manhattan include East Harlem, Central Harlem, and Manhattanville. In Brooklyn, areas of high poverty include Brownsville, Coney Island, East New York, Bedford Stuyvesant, and Bushwick, while the poorest neighborhoods in Queens are Elmhurst and Jackson Heights. A greater proportion of Brooklyn residents have supplemental nutrition assistance program (SNAP) benefits (27%) than residents in Queens (13%) and Manhattan (19%).

Homelessness and housing instability is also prevalent. In NYC, 30% households are rent burdened and ~57,000 residents sleep in homeless shelters nightly. Low-income neighborhoods in NYC have high concentrations of pubic housing and residents struggle to afford housing.

***Demographics 5:**

Disability levels:

Overall the communities analyzed in the CNA have a slightly lower disability rate (10%) than the state as a whole (11%). Brooklyn and Queens have the highest numbers of residents who are disabled. Of NYC residents ages 75 and older, 60% are disabled. Manhattan has the highest percentage of disabled elderly residents of the boroughs (61%), while Brooklyn has the greatest number of disabled seniors ages 75 and older. The rate of disabilities among NYC children ages 5-17 is lower than the state (4% versus 5%). Brooklyn has the most disabled children of the three boroughs. The most common disabilities for NYC residents are: ambulatory difficulties (27%), independent living difficulties (20%), and self-care difficulties (12%). Residents with disabilities in NYC have a lower median household income ($30,555) than non-disabled individuals ($58,072) and are more likely to live in poverty (32% compared to 14%).

***Demographics 6:**

Education levels:

Research and data show that educational attainment impacts both the likelihood of living in poverty and health outcomes. Of the residents within the CNA service area, 79% of residents graduated from high school. Manhattan has the highest levels of high school graduates (86%) and those with a bachelor's degree or higher (58%). In Brooklyn and Queens, most residents have a high school diploma (78% and 80%, respectively), but less than a third (30%) have a college degree. Additionally, illiteracy rates in Queens (46%) and Brooklyn (37%) are much higher than the NYC average (25%). In Manhattan, 40% of residents without a high school degree live in poverty compared to just 7% of residents with a bachelor's degree or higher. Similarly, in Brooklyn 34% of residents without a high school degree live in poverty compared to 9% of residents with a bachelor's degree or higher. In Queens, residents without a high school diploma are less likely to live in poverty (24%) compared to other boroughs.

***Demographics 7:**

Employment levels:

Within the broader service area analyzed in the CNA, the unemployment rate is just under 8%. Of the boroughs within the state-defined service area for MSPPS, the percentage of unemployed individuals is lowest in Manhattan (6%), followed by Queens (7%), and Brooklyn (8%). Some research suggests that individuals experiencing long-term unemployment have poorer heath outcomes, are less likely to seek health care services, and suffer from emotional distress and poor mental health.

Mount Sinai Hospitals Group (PPS ID:34)

***Demographics 8:**

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

In 2013, the broader service area analyzed in the CNA accounted for 45% of the violent crime and 40% of the non-violent crime in New York State. NYC residents represent 46% of the state prison population. After leaving state prison, 43% of released inmates return to Manhattan, Brooklyn, or the Bronx. Of offenders under custody in state prisons, 16% were classified as having a mental health diagnoses.

The jail population in NYC is mostly male (93%), with disproportionate involvement of communities of color. More than half (57%) of the NYC jail population is African American and a third of inmates (33%) are Hispanic, followed by whites (7%) and Asians (1%).

Neighborhoods within the MSPPS service area with the highest concentration of incarcerated people in the NYC corrections system include Brooklyn's Crown Heights, East New York, and Bedford Stuyvesant neighborhoods; Central Harlem and Morningside Heights in Manhattan; and Jamaica, Queens.

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

****As necessary, please include relevant attachments supporting the findings.***

File Name	Upload Date	Description
34_SEC034_Project 3.a.iii., In Full, [Mount Sinai PPS].docx	12/22/2014 11:58:17 AM	
34_SEC034_Project 2.b.iv, In Full, [Mount Sinai PPS].docx	12/22/2014 11:57:33 AM	
34_SEC034_Project 3.b.i.,Question4c, [Mount Sinai PPS].docx	12/22/2014 11:16:53 AM	

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:

The leading cause of death for NYC residents is heart disease (32%), followed by cancer (25%), pneumonia and influenza (4%), and diabetes mellitus (3%). Across racial/ethnic groups and in each of the three boroughs in the newly defined MSPPS service area, heart disease, cancer, and pneumonia/influenza are also the top three leading causes of death. The fourth leading causes of death in the three boroughs are: diabetes mellitus (Brooklyn), chronic respiratory disease (Manhattan), and cerebrovascular disease (Queens). African Americans in NYC are more likely to die of diabetes mellitus than Hispanics and whites. For both males and females, heart disease remains the leading cause of death, however, the proportions for males (approximately 233 cases/100,000 deaths) is much higher than that for females (156 cases/100,000 deaths).

Cancer is the leading cause of premature death in NYC and the three boroughs, followed by heart disease, and unintentional injury. Black and Hispanic populations have about twice the rate of premature deaths as compared with whites in all boroughs. Whites are more likely to prematurely die from heart disease (36%) than Asians (32%) and African Americans (30%).

***Challenges 2:**

Leading causes of hospitalization and preventable hospitalizations by demographic groupings:

Aside from hospitalizations related to giving birth, the leading causes of hospitalizations among Medicaid patients in the CNA service area are schizophrenia, bipolar disorder, opioid abuse/dependence, and alcohol abuse/dependence. The leading causes of ED visits for Medicaid beneficiaries in NYC are hypertension, asthma, depression, diabetes, and depressive and other psychoses.

Prevention Quality Indicators (PQIs) are a set of measures that indicate potentially preventable adult hospitalizations given early

Mount Sinai Hospitals Group (PPS ID:34)

intervention and access to increased or higher-quality outpatient care. Of the three boroughs in the MSPPS service area, preventable hospitalizations for the comorbidity of chronic obstructive pulmonary disease and asthma in older adults are highest in the Manhattan (1,147/100,000), followed by Brooklyn (758/100,000) and Queens (577/100,000). Brooklyn has the highest rate of preventable adult diabetes hospitalizations (371/100,000), followed by Manhattan (341/100,000) and Queens (296/100,000). Preventable hospitalizations for heart failure in adults is also highest in Brooklyn (318/100,000), followed by Queens (271/100,000) and Manhattan (269/100,000).

***Challenges 3:**

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

The number of visits to the ED for ambulatory care sensitive conditions (ACSCs) in the CNA service area is the highest in Manhattan (42 visits/100,000 recipients) and lowest in Brooklyn (29/100,000). Of ACSCs in this broader service area, hypertension impacts the largest number of Medicaid beneficiaries (nearly 600,000). Additionally, nearly 430,000 NYC Medicaid patients have diabetes mellitus and 300,000 have asthma. Over 90% of Medicaid providers in the MSPPS estimate that at least 40% of their patients have comorbidities, with hypertension, diabetes, and obesity being the most common.

Both hypertension and diabetes are strongly related to diet and exercise. Of NYC residents, 28% report having a poor/fair diet, 24% report obesity, and 22% report physical inactivity. Of the three counties in the MSPPS service area, these percentages are highest in Brooklyn where 30% report having a poor/fair diet, 27% report obesity, and 24% report physical inactivity.

***Challenges 4:**

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

Heart disease is the leading cause of death in all boroughs in NYC and the state. Of the 3.5 million Medicaid enrollees in NYC, 30%, or 1,110,191, have a cardiovascular disease or related disorder. Of the three boroughs within the MSPPS service area, Brooklyn has the highest number of residents with cardiovascular disease (397,513), followed by Queens (281,421), and Manhattan (170,110).

Nearly a million NYC Medicaid beneficiaries (939,056 individuals), are diagnosed with a mental health condition or substance abuse disorder. Of the three boroughs within the MSPPS service area, Brooklyn has the highest number of residents with a mental health disorder (219,397), followed by Queens (133,250), and Manhattan (130,069). In terms of substance abuse disorders diagnoses among Medicaid beneficiaries in these boroughs, Brooklyn has highest number (63,171), followed by Manhattan (54,266), and Queens (26,264).

Of NYC Medicaid beneficiaries with a mental health disorder, one in four are diagnosed with depression (24%), followed chronic stress/anxiety (15%), and schizophrenia (11%). Many individuals with mental health conditions have comorbidities, including substance abuse disorders, cardiovascular disease, and diabetes.

About one in ten NYC Medicaid enrollees (410,083) have diabetes. Of the three boroughs within the MSPPS service area, Brooklyn has the highest number of residents with diabetes (139,781), followed by Queens (105,074), and Manhattan (60,619).

Out of the 53,901 Medicaid beneficiaries living with HIV in New York State, 92% live in NYC. Despite only representing 8% of the statewide population, Manhattan has 26% of the new HIV diagnoses. Of the total HIV positive individuals in NYC, 67% live in Brooklyn (16,623), Manhattan (10,018), and Queens (6,984). The population in the CNA service area has considerably higher case rates of STDs (gonorrhea, chlamydia, syphilis, etc.) when compared to the state, with prevalence rates as high as 650 per 100,000 individuals for some age groups.

Qualitative data from our provider CNA survey indicate that many Medicaid patients have co-morbidities. Of providers surveyed, 91% estimated that among their Medicaid patients, 40% or more had comorbidities, with 36% estimating that 80-100% of their Medicaid patients have comorbidities and 31% estimating that 60-80% of their Medicaid patients have comorbidities. When providers were asked to rank the top three most common morbidities experienced by their Medicaid patients, the highest ranked responses were diabetes, hypertension, and obesity.

***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:

Mount Sinai Hospitals Group (PPS ID:34)

NYC fares worse than the state in perinatal deaths, with a rate of 11.9 deaths per 1,000 births, compared to the statewide rate of 9.8 deaths per 1,000 births. NYC has an overall infant mortality rate of 4.5 per 1,000 births, which is lower than the state rate (5.0). Of the three boroughs within the MSPPS service area, Queens has the highest infant mortality rate (4.9 deaths per 1,000 live births), while Manhattan has the lowest (2.9). Maternal mortality in NYC was 25.5 per 100,000 women in 2012.

Of babies born in NYC, 10,096, or 8.5%, were low birth weight (less than 2,500 grams), a percentage slightly higher than the state (8.1%). Likewise, NYC's percentage of premature births is also slightly higher than the state as whole (11.3% compared to 11.1%). Of the boroughs within the MSPPS service area, Brooklyn has both the highest percentage of babies born at low birth weight and premature births, indicating a need for greater access to prenatal care.

Rates of birth defects vary across the three boroughs in the MSPPS service area, with a higher rate in Brooklyn (273 per 10,000 live births). However, all boroughs remain within 20% of the state average (251.5/10,000 live births).

***Challenges 6:**

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

The percentage of obese adults in the service area analyzed in the CNA is the same statewide; both are 23%. However, obesity rates in the three boroughs of the MSPPS service area vary. In Manhattan, 16% of adults are obese, followed by Queens (23%), and Brooklyn (26%). The percentage of young children participating in the Women, Infants, and Children (WIC) program that are obese is the same both statewide and in NYC at 14%, with Queens having the greatest proportion of obese children (16%) of the three boroughs. Residents in Brooklyn and Queens are also more likely to report being physically inactive and having a poor or fair diet than Manhattan residents, likely contributing to the higher rates of obesity in these boroughs.

Of the three boroughs, the number of Medicaid beneficiaries who chronically abuse alcohol is highest in Brooklyn (14,587), followed by Manhattan (12,012), and Queens (7,816). The numbers of beneficiaries who abuse opioids is highest in Brooklyn (11,155), followed by Manhattan (9,528), and Queens (4,169). Although recent data show that smoking is on the rise in NYC, the overall percentage of NYC adult smokers is the same as the state rate (both are at 15.6%).

***Challenges 7:**

Any other challenges:

Research shows that frequent users of emergency departments (EDs) in NYC have multiple chronic conditions. Of Medicaid patients that visit the ED at least 15 times in one year, 85% had more than one chronic condition. The complexity of this population's health status requires greater coordination of care beyond simply increasing access to primary care. Neighborhoods in NYC with rates of ED use include those that are predominantly African American, Hispanic, and impoverished. Frequent users oftentimes experience housing instability, which is closely linked to poor health outcomes. Research has shown that supportive housing can reduce Medicaid costs.

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**.

A major service gap for the Medicaid population in the service area analyzed in the CNA is a lack of access to primary care facilities in underserved communities and inadequate care coordination. Providers report it is much easier for beneficiaries to access care through an emergency department (ED) than through a primary care or specialty provider, or when experiencing a mental or behavioral health episode. In the NYC area, the top five causes of ED visits for Medicaid beneficiaries (outside of pregnancy-related issues) were hypertension, asthma, depression, diabetes, and depressive and other psychoses. There are far fewer unique Medicaid ED users than visits, suggesting the ED is a primary source of care for beneficiaries. As a result, all boroughs have high Prevention Quality Indicator (PQI) and Potentially Preventable Emergency Visit (PPV) rates. A significant number of hospitalizations can be prevented, but to keep people out of the hospital and in their communities will require a shift in resources and delivery system integration.

Mount Sinai Hospitals Group (PPS ID:34)

A key goal of DSRIP is to reduce avoidable hospital use by improving integration across the health care system and helping Medicaid beneficiaries navigate across the continuum of providers and access the care they need. Despite high numbers of beneficiaries with chronic diseases and other significant health needs, there is a lack of available services. In addition to the scarcity of primary care and community-based behavioral health services, care coordination and information sharing platforms are lacking. Providers are locked into silos, without incentives or avenues to improve integration.

The MSPSS service area is characterized by an overabundance of and overreliance on institutional providers, namely acute care hospitals. In analysis of acute care hospital bed utilization for a sub-set of major hospitals within the CNA service area, hospital bed utilization ranges from a low of 64% to 94%, suggesting some degree of excess bed capacity and an overreliance on hospital services. Likewise, roughly 7% of nursing home beds are not being utilized in the service area analyzed in the CNA. This misallocation of resources limits the primary and preventive care that can reduce unnecessary hospitalizations. As patients transition out of the hospital, resources have not been fully reallocated to less-restrictive settings. Additionally, current spending on behavioral health is heavily weighted towards emergency and inpatient settings, rather than community-based and outpatient settings. Another component of DSRIP will be to reconfigure resources to move away from the institutional bias and towards evidence-based, high quality care in the right setting at the right time.

***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.

In a survey of MSPPS providers, respondents were asked to rank barriers to effective care coordination. The top three barriers ranked by providers are: fragmented or stand-alone services (rather than an integrated delivery system), complexity of coordination for patients with high levels of need and/or with frequent hospital and clinic visits, and practice norms that encourage clinicians to act in silos rather than coordinate with each other.

In addition to these systemic issues, the populations in the MSPPS service areas – particularly the underserved areas of Brooklyn and Queens – also face significant socioeconomic barriers to navigating the health care system. Many are foreign-born, speak a language other than English, and are more likely to be illiterate or have low education level. Residents face high housing costs and are food insecure due to low income and relatively high unemployment rates.

Many of these socioeconomic conditions are associated with poor health outcomes, including higher levels of unmanaged chronic conditions such as hypertension and diabetes, ED usage, and untreated mental health issues such as depression and schizophrenia. An integrated health system that is designed to help this population access services and ensure appropriate follow-up can significantly reduce unnecessary hospital utilization while improving population health.

***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.

Overall, the goal of the MSPPS is to create an integrated care delivery system focused on evidence-based medicine and population health management. MSPPS will achieve this through several strategies. A focus on care transitions will connect patients with the care they need to recover or maintain health, as well as learn self-management of chronic conditions. Community-based health navigation services will help individuals overcome the socioeconomic barriers to the health care system in a culturally and linguistically appropriate manner. Strategies focused on key health issues in the MSPPS service area such as mental health, substance abuse, HIV, diabetes, and cardiovascular health will focus on the ED "frequent fliers" and other populations underserved by existing community resources. Together, this can reduce unnecessary hospital utilization and readmissions. The result will be reorienting available services from institutional to community settings, and reallocating resources both across the spectrum of care and across the geographic service area.

Section 3.7 - Stakeholder & Community Engagement:

Description:

Mount Sinai Hospitals Group (PPS ID:34)

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).

We distributed a CNA survey to our partners that was designed to gather their on-the-ground insights on key community health needs and barriers to accessing care. This survey was comprised of 62 questions divided into six components - Organizational Information, Access to Health Care Services, Care Coordination, Population Health, Health Care Barriers, and Patient Centered Medical Homes. Of the 200 parent organizations and unique standalone organizations in our PPS, 190 completed and submitted a survey.

The extensive quantitative data that we collected from our partners provided a wealth of comprehensive information on the health status and community needs in the PPS service area. At our October 16th Town Hall, which was open to all of our partners and potential partners, an analysis of topline results from the data was shared. This was an opportunity not only to share results, but also to gather insights and feedback on the assessment from our partners. Following the Town Hall, we distributed the feedback we received and our survey to our committees, and incorporated their responses into the final survey and project planning. In addition to the Town Hall, our website describes our approach to CNA and major steps we took in creating the assessment.

***Community 2:**

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

We engaged with community members to inform them on the DSRIP process and to solicit their feedback on their perception of community need through multiple venues. Through community-level meetings we were able to discuss the overarching goals and changes associated with DSRIP, and discuss community health needs, service gaps, and garner public feedback.

We held several meetings in Brooklyn in association with our lead partner, the Brooklyn Hospital Center (TBHC). Through TBHC, we connected with the Brooklyn Perinatal Network where we had the opportunity to work with a unique set of our partners and providers outside of our PPS and engage in a dialogue around health disparities in Brooklyn.

Additionally, we participated in multiple Community Board meetings where specific community health needs were discussed in relation to the overarching goals of DSRIP and MSPPS. Through the Community Boards affiliated with the Mount Sinai hospitals we led three unique presentations each of which had an average of 15 participants. These small group settings allowed us to lead a candid dialogue with participants so we could hear their thoughts, questions, and provide a venue for potential concerns.

***Community 3:**

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

As we worked with our stakeholders and the broader community on this process, we gained valuable insight through their questions and concerns. Three key issues were raised frequently and they centered around access to primary care, IT infrastructure, and financial concerns.

One of the issues highlighted at the consumer-level was the need for better health IT systems so that their providers could communicate and coordinate with one another. These discussions continued to highlight that one of the largest challenges in their communities is around access to and coordination of care. Both of these issues need to be addressed at the root of the problem by connecting providers through improved databases to better facilitate patient navigation, care and communication.

In addition, and related to these IT concerns, we received feedback on whether these changes would be feasible based on the patient demographics and the wide range of providers within our service area. To successfully implement, the feedback we received showed that this would take significant financing that many smaller community-based organizations may not be able to take on and contribute.

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

Mount Sinai Hospitals Group (PPS ID:34)

[Mount Sinai Hospitals Group] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
1	Abbott House (Advance Care Alliance Member Agency)	Offers a full continuum of developmental disability services in the five boroughs of NYC and Westchester County, with many culturally competent and language-specific programs.	One goal of the MSPPS is to create an integrated delivery system that is community-based and incorporates a full continuum of services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
2	Access Community Health Center	Their facilities offer medical and dental care; addiction recovery; physical, occupational, and speech; psychiatry and neuropsychology; podiatry, social work, and STD / HIV screening and treatment. They provide culturally competent, quality health care to all regardless of ability to pay.	One goal of the MSPPS is to create an integrated delivery system that is community-based, and incorporates a full continuum of services. Another goal is to increase early access to, and retention in, HIV care. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
3	ACMH, Inc.	ACMH, Inc. promotes the wellness and recovery of people living with mental illness in New York City by providing access to resources, treatment, support, and supportive housing for people who qualify.	One goal of the MSPPS is to integrate primary care services and behavioral health. This includes integrating services and supports such as housing. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
4	AgeWell New York	AgeWell is an HMO plan that offers a variety of HMOs, HMO SNPs, and Medicare Advantage products for seniors living in New York State.	One goal of the MSPPS is to create an integrated delivery system that is community-based, and incorporates a full continuum of services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
5	AIDS Service Center NYC d/b/a Allied Service Center NYC (ASCNYC)	ASCNYC supports HIV-positive New Yorkers by offering a range of professional services including health care, social services, peer education, and safe-practice counseling.	One goal of the MSPPS is to increase early access to, and retention in, HIV care. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
6	Alpine Home Health Care	Alpine provides education and teaching on disease management.	One goal of the MSPPS is to use evidence based strategies for disease management in patients who are high risk. This includes services for people with diabetes and cardiovascular disease. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
7	Amber Court Assisted Living Communities	Assisted living facility that assesses resident needs in order to provide care that optimizes their quality of	One goal of the MSPPS is to create an integrated delivery system that is

Mount Sinai Hospitals Group (PPS ID:34)

[Mount Sinai Hospitals Group] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		life.	community-based, and incorporates a full continuum of services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
8	American Dental Offices, PLLC	These dental offices typically serve areas heavily populated by Medicaid recipients, and offer full-service (general and specialty), effective, and efficient dentistry services that focusing on preventative measures and general patient education. The offices serve patients of all ages.	One goal of the MSPPS is to create an integrated delivery system that is community-based, and incorporates a full continuum of services. This includes dental services. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
9	Americare, Inc.	Assists clients with a smooth transition from hospital to home and assures no return to hospital for minimum of 30 days. They also manage clients' medication.	One goal of the MSPPS is to use the care transition model to reduce 30 day hospital readmissions for chronic health conditions through the use of community-based support services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
10	Amsterdam Nursing Home Corporation	This nursing home offers an array of individualized treatment, including: clinical services; short- and long-term rehabilitation; physical and occupational therapy; social work; and personal care.	One goal of the MSPPS is to create an integrated delivery system that is community-based, and incorporates a full continuum of services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
11	ANIBIC	A non-profit organization that supports children and adults with neurological disabilities to achieve their fullest potential with education, vocational training, legislation, and professional development.	One goal of the MSPPS is to create an integrated delivery system that is community-based, and incorporates a full continuum of services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
12	Apicha Community Health Center	Community health center serving vulnerable populations in New York City, with specific competencies for Asians, Pacific Islanders, LGBTQI individuals, and people living with / affected by HIV/AIDS. Services for people who are HIV positive include: care coordination / management, nutrition health information, psychosocial education and support groups. They also specialize in transgender and gender non-	One goal of the MSPPS is to create an integrated delivery system that is community-based, and incorporates a full continuum of services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS

Mount Sinai Hospitals Group (PPS ID:34)

[Mount Sinai Hospitals Group] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		conforming patients with primary care and hormone replacement therapy (Initiation and continuation). Consumers can also enroll in health insurance programs via NYS Marketplace, assist qualified people in applying for SNAP, anal cancer preventative screenings, HIV primary care, and PrEP for primary care patients.	project.
13	ArchCare	The Continuing Care Community of the Archdiocese of New York. They provide a wealth of community care services, including care navigation, SNP, PACE, and MLTCP health plans, home care, short-term rehab, nursing homes, end-of-life care, and specialized care.	One goal of the MSPPS is to create an integrated delivery system that is community-based, and incorporates a full continuum of services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
14	AREBA Casriel, Inc	A private New York City-based facility that treats people suffering from substance abuse and addiction. Programs include detoxification and rehabilitation, in both inpatient and outpatient settings, and they accept Medicaid.	One goal of the MSPPS is to integrate primary care services and behavioral health. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
15	Arms Acres and Conifer Park	Private health care systems that provide professional treatment to people suffering from chemical dependency, co-occurring medical and mental health disorders and people struggling with addiction. They provide both inpatient and outpatient services.	One goal of the MSPPS is to integrate primary care services and behavioral health. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
16	ASBM (ACA member agency)	Advocates for Services to the Blind serves people with a wide variety of developmental, neurological, and physical disabilities, helping them to achieve their fullest potential. They offer a residential program, day programs, and medical service coordination to develop individualized service plans.	One goal of the MSPPS is to create an integrated delivery system that is community-based, and incorporates a full continuum of services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
17	Astor Services for Children & Families (Coordinated Behavioral Care IPA Network Member Agency)	A non-profit organization that provides children's mental health services, child welfare services, and early childhood development programs for children in the Mid-Hudson Valley region and the Bronx. The organization offers early intervention preventative programs, early childhood programs, mental health programs (for children and their families alike), and residential treatment programs.	One goal of the MSPPS is to create an integrated delivery system that is community-based, and incorporates a full continuum of services. This includes mental and behavioral services and supports for children. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
18	Bailey House	A group that supports people living with HIV/AIDS, offering support groups, transitional housing, residential family case management, and confidential, bilingual drop-in services. The center also offers Access to Language Line, Proficiency in Care Management, Trauma Informed Services, and wrap around services with housing, mental health, groups, a food pantry, and care management.	One goal of the MSPPS is to increase early access to, and retention in, HIV care. This includes providing community-based social supports. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.

Mount Sinai Hospitals Group (PPS ID:34)

[Mount Sinai Hospitals Group] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
19	Bay Park Center for Nursing & Rehabilitation	A skilled nursing facility serving the Bronx, Manhattan, Queens, Staten Island, Brooklyn, and Westchester County. Services include PICC lines, IV fluids, IV Antibiotics, diabetes management, hospice / pallative care, respite care, oxygen therapy, tracheostomy care, bi-pap/CPAP, negative pressure therapy (Wound Vac), surgical wound care (includes weekly rounds with surgeon), and physical, occupational and speech therapy services. They also offer programs for people with Alzheimer's / dementia.	One goal of the MSPPS is to create an integrated delivery system that is community-based, and incorporates a full continuum of services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
20	Bedford-Stuyvesant Family Health Center	A non-profit family health center in Brooklyn that offers preventative care, primary care, mental health services and others. Additional specialties include cardiology, dentistry, diabetes management, eye exams, HIV/AIDS services, nutrition, pediatrics, podiatry, surgery consultation, and women's health. They also offer insurance enrollment assistance, health education, case management, interpreter services, housing assistance, Access-a-Ride, and employment and education counseling.	One goal of the MSPPS is to create an integrated delivery system that is community-based, and incorporates a full continuum of services. This includes a full range of medical services and social supports. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
21	Betances Health Center	Provides health care services for all, regardless of ability to pay. The organization offers several more specialized programs, including a nutrition and fitness program for patients struggling with diabetes or obesity. They also do HIV case management and the use of acupuncture, acupressure, and essential oils workshops for patient education.	One goal of the MSPPS is to create an integrated delivery system that is community-based, and incorporates a full continuum of services. Another goal is to increase access to high quality chronic disease preventive care and management in clinical and community settings. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
22	Bishop Henry Hucles	A skilled nursing facility with specialties including: IV therapy, tracheotomy care, wound care specialists, full-time attending physicians, dementia unit, palliative and hospice care, beauty / barber services, and pastoral care.	One goal of the MSPPS is to create an integrated delivery system that is community-based, and incorporates a full continuum of services. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
23	Blythedale Children's Hospital	Pediatric specialty hospital, one of 19 in the country. Their services include ventilator transition, traumatic / acquired brain injury treatment, organ transplants, nutritional support, burn / wound care, cancer, genetic disorders, a hemiplegia center, day hospital program, and links to community programs in the region.	One goal of the MSPPS is to create an integrated delivery system that is community-based, and incorporates a full continuum of services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
24	BOOM!Health	Serves New Yorkers at a high risk for illness, addiction, homelessness, and poverty to access health care services that would otherwise be unreachable or unaffordable. Some services include: health home care management, harm reduction counseling, syringe exchange, food and nutrition	One goal of the MSPPS is to create an integrated delivery system that is community-based, and incorporates a full continuum of services. This includes food and nutrition services. This organization responded to the

Mount Sinai Hospitals Group (PPS ID:34)

[Mount Sinai Hospitals Group] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		services, HIV and HCV prevention, testing and linkage to care, and care coordination.	MSPPS survey and was engaged in the development of the MSPPS project.
25	Bridge Back to Life Center, Inc.	Outpatient treatment for people struggling with addiction and alcoholism. Clients receive an evaluation and then work with counselors to develop new coping strategies.	One goal of the MSPPS is to create an integrated delivery system that is community-based, and incorporates a full continuum of services. This includes providing behavioral health services in the community. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
26	Brooklyn Community Services	BCS' aim is to support children and families in growing into positive, productive members of society. Programs include early childhood and youth development, family counseling, mental health services, and specific programs for people with developmental disabilities.	One goal of the MSPPS is to create an integrated delivery system that is community-based, and incorporates a full continuum of services. This includes mental and behavioral services and supports for children. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
27	Brooklyn Plaza Medical Center, Inc.	The Center offers patient navigation, interpretive services, CSAC, insurance enrollment, PCAP, psycho-social assessment, nutrition, patient portal	One goal of the MSPPS is to develop community–based health navigation services that assist patients in scheduling appointments and obtaining community services. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
28	Cabrini of Westchester	Care center that takes patients for all different lengths of time, from temporary respite to long-term skilled nursing facility care. The center also has sub-acute/short term rehabilitation, post-surgical rehabilitation, adult day health care, social day care, dementia and Alzheimer's care programs, respite care, and palliative care.	One goal of the MSPPS is to create an integrated delivery system that is community-based, and incorporates a full continuum of services. This includes people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
29	Cabs Nursing Home	Nursing home that includes clinical laboratory services, dental, mental health, nursing services, physical / occupational / speech therapy, physician, podiatry, social work, and speech / language pathology	One goal of the MSPPS is to create an integrated delivery system that is community-based, and incorporates a full continuum of services. This includes people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
30	Callen-Lorde Community Health Center	A New York City community health center that primarily serves the LGBTQI community. Services include care coordination, dental, health education (to myriad age groups), HIV/AIDS services, mammography, mental health, pharmacy, primary care, and transgender health services.	One goal of the MSPPS is to create an integrated delivery system that is community-based, and incorporates a full continuum of services. This includes services for special needs and underserved populations. This organization responded to the

Mount Sinai Hospitals Group (PPS ID:34)

[Mount Sinai Hospitals Group] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			MSPPS survey and was engaged in the development of the MSPPS project.
31	CareRite Centers - The Riverside	A nursing facility with specialties in short-term rehab and long-term care. Available therapies include: cardiac, dysphagia, pulmonary, physical, neurological, orthopedic, occupational, and speech therapy; nutrition support; sensory stimulation; art, music, and dance therapy; self-care training and discharge planning.	One goal of the MSPPS is to create an integrated delivery system that is community-based, and incorporates a full continuum of services. This includes people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
32	CASES (Coordinated Behavioral Care IPA Network Member Agency)	Works with people to improve behavioral health and move towards responsible behavior and self-sufficiency following incarceration.	One goal of the MSPPS is to create an integrated delivery system that is community-based, and incorporates a full continuum of services. This includes behavioral health services. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
33	Catholic Guardian Services	Seeks to protect and nurture disadvantaged children and others living with disabilities to increase their self-sufficiency, strengthen their family structures, and adapt responses to their needs. Services address developmental disabilities, family permanency, family support, and maternity issues.	One goal of the MSPPS is to develop community–based health navigation services that assist patients in scheduling appointments and obtaining community services. This includes social services and supports for underserved children. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
34	Catholic Charities Neighborhood Services, Inc.	Catholic-based philanthropic organization that offers myriad services, including: behavioral health, early childhood services, housing, family, professional development, support for people with developmental disabilities, and advocacy.	One goal of the MSPPS is to develop community–based health navigation services that assist patients in scheduling appointments and obtaining community services. This includes services like housing and professional development. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
35	Center for Urban Community Services	Works to rebuild the lives of homeless and disadvantaged families. Services include housing, street outreach, primary / psychiatric care, access to public benefits and referrals, employment assistance, help with reentry following incarceration, and scholarships.	One goal of the MSPPS is to develop community–based health navigation services that assist patients in scheduling appointments and obtaining community services. This includes services like housing and employment. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
36	Centers for Specialty Care Group	Consortium of 23 healthcare and rehabilitative centers who provide services to all. Services include a complex medical care program, hip / joint replacement recovery, medical shuttle, on-site	One goal of the MSPPS is to create an integrated delivery system that is community-based, and incorporates a full continuum of services. This

Mount Sinai Hospitals Group (PPS ID:34)

[Mount Sinai Hospitals Group] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		dialysis, pain management, post-surgery orthopedic care, and myriad forms of therapy: amputee, cardiac, IV antibiotic, occupational, physical, recreational, respiratory, speech, and stroke therapy.	includes people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
37	Children's Collaborative	Coalition of 19 children- and family-focused agencies that provide home services to children. Services include care management, waiver services, special education programs, behavioral health and medical services, and childhood / after-school programs.	One goal of the MSPPS is to develop community–based health navigation services that assist patients in scheduling appointments and obtaining community services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing home services to children. Services include care management, waiver services, special education programs, behavioral health and medical services, and childhood / after-school programs.
38	City Health Works	City Health Works coaches work with their clients to better control and help prevent chronic illnesses, including asthma, diabetes, and hypertension.	One goal of the MSPPS is to increase access to high quality chronic disease preventative care and management in both clinical and community settings. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by coaching patients to better control and help prevent chronic illnesses, including asthma, diabetes, and hypertension.
39	Cobble Hill Health Center Inc.	Health care system specially targeted at older adults, the chronically ill, and people living with disabilities or who are debilitated from a hospital stay. The center has experience with care management teams for member coordination for MLTC; CCTP (care transitions experience), and experience with ISNP and bundled payments systems.	One goal of the MSPPS is to increase access to high quality chronic disease preventative care and management in both clinical and community settings. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
40	Community Access	This organization offers a range of housing, job skills, employment placement and support services to help end homelessness, institutionalization and incarceration that impacts the lives of people who struggle with mental illness.	One goal of the MSPPS is to develop community–based health navigation services that assist patients in scheduling appointments and obtaining community services. This includes services like housing and professional development. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.

Mount Sinai Hospitals Group (PPS ID:34)

[Mount Sinai Hospitals Group] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
41	Community Care Management Partners (CCMP) Health Home	The CCMP network includes roughly 100 hospitals, medical providers, outpatient mental health care and substance use providers, housing providers and community-based social services organizations who help coordinate a person's health services so they work together better.	One goal of the MSPPS is to create an integrated delivery system that is community-based, and incorporates a full continuum of services. This includes medical care, behavioral health care, and social supports. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
42	Community Healthcare Network	A network of not-for-profit community health centers providing medical, dental and social services in neighborhoods throughout New York City. Social work, Health Education, Care Management, Nutrition, ADAP, Health Literacy, Treatment Adherence, CAC Patient Navigators, and others.	One goal of the MSPPS is to develop community–based health navigation services that assist patients in scheduling appointments and obtaining community services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing medical, dental and social services in neighborhoods throughout New York City including: social work, health education, care management, nutrition, ADAP, health literacy, treatment adherence, CAC patient navigators, and others.
43	Comunilife	A New York City community-based health and housing service providers that supports the needs of about 3,000 low-income New Yorkers. Their transitional, congregate, and scatter site housing supports people living with HIV/AIDS. Their outpatient mental health clinic, safe haven residences, community residences, and a specialized care program for elderly Latinos. They also host a suicide prevention program.	One goal of the MSPPS is to create an integrated delivery system that is community-based, and incorporates a full continuum of services. This includes social supports like housing, and mental health services. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
44	Coordinated Behavioral Care IPA Network Member Agency	The CBC network offers a full continuum of behavioral health care in the five boroughs of NYC, with many culturally competent programs offered in a variety of languages. They also include many of the licensed and supportive housing programs in NYC serving people with behavioral health disorders. More than 30 provider agencies in CBC's network are delegated care management providers.	One goal of the MSPPS is to create an integrated delivery system that is community-based, and incorporates a full continuum of services. This includes medical care, behavioral health care, and social supports. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
45	Dominican Sisters Family Health Service, Inc.	The organization is a CMS community-based care transitions program in Suffolk County. They provide compassionate, comprehensive and family-focused home care.	One goal of the MSPPS is to create hospital-home care collaboration solutions. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing community-based care

Mount Sinai Hospitals Group (PPS ID:34)

[Mount Sinai Hospitals Group] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			transitions program in Suffolk County. They provide compassionate, comprehensive and family-focused home care.
46	EAC	A non-profit human service agency that works to protect children, empower and strengthen families, support people struggling with addiction, and connect with seniors.	One goal of the MSPPS is to create an integrated delivery system that is community-based, and incorporates a full continuum of services. This includes mental and behavioral services and supports for children. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
47	Educational Alliance, Inc.	Licensed Social Workers provide individual and group treatment for people dealing with drug abuse and other issues. They also serve older adults, parents, and youth, as well as sponsoring fitness programs and youth camps.	One goal of the MSPPS is to create an integrated delivery system that is community-based, and incorporates a full continuum of services. This includes mental and behavioral services and supports for children. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
48	Empire Home Care	They provide home health aides, medical social services, medical supplies, nursing, nutritional programs, and physical / occupational / speech therapy.	One goal of the MSPPS is to create hospital-home care collaboration solutions. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing home health aides, medical social services, medical supplies, nursing, nutritional programs, and physical / occupational / speech therapy.
49	Episcopal Social Services	Religious-affiliated organization that offers early childhood and after-school education, developmental disabilities services, juvenile justice reform, family stabilization, family strengthening, foster care, adoption, youth development, counseling, skills training, pediatric medicine, child psychiatry, child psychology, and dental services.	One goal of the MSPPS is to create an integrated delivery system that is community-based, and incorporates a full continuum of services. This includes mental and behavioral services and supports for children. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
50	Federation of Organizations (Coordinated Behavioral Care IPA Network Member Agency)	An umbrella organization that encompasses regional groups that provide clinical, financial, residential, and employment services; senior support services, including the foster grandparent and senior companion programs; and nursing homes, among other programs.	One goal of the MSPPS is to develop community–based health navigation services that assist patients in scheduling appointments and obtaining community services. This includes services like housing and employment. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.

Mount Sinai Hospitals Group (PPS ID:34)

[Mount Sinai Hospitals Group] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
51	FEGS Health & Human Services	FEGS is a large Health and Human Service agency that provides both clinic and social services such as employment, residential and educational support.	One goal of the MSPPS is to develop community–based health navigation services that assist patients in scheduling appointments and obtaining community services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing both clinic and social services such as employment, residential and educational support.
52	Four Seasons Nursing & Rehabilitation Center	A center offering physical / occupational / speech therapy, long-term care, hospice, IV therapy, respiratory vent unit, dialysis, an adult day center, and home healthcare.	Two goals of the MSPPS are to (1) create hospital-home care collaboration solutions and (2) use the care transition model to reduce 30 day hospital readmissions for chronic health conditions through the use of community-based support services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing physical / occupational / speech therapy, long-term care, hospice, IV therapy, respiratory vent unit, dialysis, an adult day center, and home healthcare.
53	GMHC	GMHC directly offers: HIV testing and counseling, case management services, mental health services, substance use counseling, social work services, nutritional counseling, health insurance and benefits enrollment assistance and advocacy, housing assistance, and other supportive services, including legal assistance, hot meals and food pantry, workforce development services, and holistic wellness services.	Two goals of the MSPPS are to (1) increase early access to, and retention in, HIV care and (2) develop community–based health navigation services that assist patients in scheduling appointments and obtaining community services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing HIV testing and counseling, case management services, mental health services, substance use counseling, social work services, nutritional counseling, health insurance and benefits enrollment assistance and advocacy, housing assistance, and other supportive services, including legal assistance, hot meals and food pantry, workforce development services, and holistic wellness services.

Mount Sinai Hospitals Group (PPS ID:34)

[Mount Sinai Hospitals Group] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
54	God's Love We Deliver	Inclusion of medically tailored home-delivered meals in the medical care for high-risk beneficiaries accomplishes all three goals of the Triple Aim. The positive health impact of food and nutrition services (FNS) for diseases such as diabetes, cardiovascular disease and other nutrition-responsive illnesses has been well documented.	One goal of the MSPPS is to create hospital-home care collaboration solutions. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing medically tailored home-delivered meals in the medical care for high-risk beneficiaries.
55	Good Shepherd Services	This organization operates programs to help at-risk youth safely become more self-sufficient with family- and school-based services.	One goal of the MSPPS is to create an integrated delivery system that is community-based, and incorporates a full continuum of services. This includes social supports for children. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
56	Goodwill Industries of Greater New York and Northern New Jersey, Inc.	Empowers people with disabilities and other barriers to find gainful employment and build stronger communities.	One goal of the MSPPS is to develop community–based health navigation services that assist patients in scheduling appointments and obtaining community services. This includes services like housing and employment. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
57	Greenwich House, Inc.	Their program offers arts, music, senior services, children's safety programs. Their chemical dependency help and direct clinical care reduces use of hospital ED visits.	One goal of the MSPPS is to create an integrated delivery system that is community-based, and incorporates a full continuum of services. This includes social supports and services. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
58	Hand in Hand Family Services (Advance Care Alliance Member Agency)	Hand in Hand offers an after-school respite program, social skills and activities of daily living development, Medicaid coordination, at-home respite, supportive apartments, financial management, and other support services.	One goal of the MSPPS is to develop community–based health navigation services that assist patients in scheduling appointments and obtaining community services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing an after-school respite program, social skills and activities of daily living development, Medicaid coordination, at-home respite, supportive apartments, financial management, and other support services.
59	Harlem United / URAM	An organization committed to providing care for	One goal of the MSPPS is to

Mount Sinai Hospitals Group (PPS ID:34)

[Mount Sinai Hospitals Group] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		people infected by, or threatened by, HIV/AIDS, and to work towards prevention and the best possible health outcomes for people with AIDS.	increase early access to, and retention in, HIV care. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing care for people infected by, or threatened by, HIV/AIDS, and by working towards prevention and the best possible health outcomes for people with AIDS.
60	HeartShare Human Services of New York	A non-profit organization that offers residential programs, adult day programs, childhood services, Medicaid service coordination, parents training, and care coordination for duals.	One goal of the MSPPS is to develop community–based health navigation services that assist patients in scheduling appointments and obtaining community services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing residential programs, adult day programs, childhood services, Medicaid service coordination, parents training, and care coordination for duals.
61	Hempstead Park Nursing Home	Nursing home with a lab, dentist, x-ray, nutrition, housekeeping, mental health, physical / occupational / speech therapy, podiatry, social work, and speech / language pathology services are available, among others.	One goal of the MSPPS is to create hospital-home care collaboration solutions. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing nursing home services including a lab, dentist, x-ray, nutrition, housekeeping, mental health, physical / occupational / speech therapy, podiatry, social work, and speech / language pathology services are available, among others.
62	Henry Street Settlement	An organization that offers empowerment services including arts, employment, senior services, transitional housing, and youth programs.	One goal of the MSPPS is to develop community–based health navigation services that assist patients in scheduling appointments and obtaining community services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing empowerment services including arts, employment, senior services,

Mount Sinai Hospitals Group (PPS ID:34)

[Mount Sinai Hospitals Group] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			transitional housing, and youth programs
63	Housing Works	An organization committed to serving people affected by HIV/AIDS. Services include medical and dental care, behavioral health, care management, supportive services, housing resources, and other providers.	One goal of the MSPPS is to increase early access to, and retention in, HIV care. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing medical and dental care, behavioral health, care management, supportive services, housing resources, and other providers to people affected by HIV/AIDS.
64	ICL (Coordinated Behavioral Care IPA Network Member agency)	ICL provides services for children and families, mental health services, intellectual / developmental disabilities, health care and wellness management, residential and housing services, veterans services, and clinical services, among others.	One goal of the MSPPS is to integrate primary care services and behavioral health. This includes services for people with disabilities and special needs This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing services to children and families, mental health services, intellectual / developmental disabilities, health care and wellness management, residential and housing services, veterans services, and clinical services, among others.
65	Iris House	They provide care coordination, behavioral health, and case management for women, families, and other populations affected by health disparities.	One goal of the MSPPS is to develop community–based health navigation services that assist patients in scheduling appointments and obtaining community services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing care coordination, behavioral health, and case management for women, families, and other populations affected by health disparities.
66	Isabella	They provide direct clinical care, including a newly expanded certified ventilator unit, dementia, and post-acute rehab. Other programs include: home- & community-based services, diabetes; care management, and Health Home Partners.	One goal of the MSPPS is to create hospital-home care collaboration solutions. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing home & community-based services, diabetes; care management, and Health Home Partners.

Mount Sinai Hospitals Group (PPS ID:34)

[Mount Sinai Hospitals Group] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
67	Jewish Board of Family and Children's Services	This organization provides services for adults living with mental illness, child & adolescent services, community counseling, domestic violence, skill-building for people with developmental disabilities, and professional training for people in family and human services careers.	One goal of the MSPPS is to develop community–based health navigation services that assist patients in scheduling appointments and obtaining community services. This includes services like housing and employment. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project.
68	Jewish Child Care Association	An organization that provides quality services to children and their families by providing foster care, adoptive services, special needs programs, residential programs, community and mental health programs. They also connect people to resources for child, autism, and child abuse issues.	One goal of the MSPPS is to develop community–based health navigation services that assist patients in scheduling appointments and obtaining community services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing quality services to children and their families by providing foster care, adoptive services, special needs programs, residential programs, community and mental health programs. They also connect people to resources for child, autism, and child abuse issues.
69	Jewish Home Lifecare	JHL has all components for home & community based services. The CHHA has a hospitalization rate below State and National levels and uses telehealth, their licensed agency has trained home health aides specializing in telehealth. They also have both medical and social day care programs in 3 counties, 5 NORC partnerships and supportive housing programs. JHL also provides geriatric care management , behavioral health programs and specialized post-acute units in cardiac rehabilitation, enhanced rehab for spine and orthopedic patients. They also have low vision units, in-house dialysis, a geriatric substance abuse unit, and a community dementia care and navigator program.	One goal of the MSPPS is to create hospital-home care collaboration solutions. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing all components for home and community based services including: trained health aides, medical and social day care programs, geriatric care management , behavioral health programs and specialized post-acute units in cardiac rehabilitation, enhanced rehab for spine and orthopedic patients. They also have low vision units, in-house dialysis, a geriatric substance abuse unit, and a community dementia care and navigator program.
70	Leake & Watts Services (Children's Collaborative)	This organization helps vulnerable and at-risk children and families by providing a wide range of services including special education, early childhood development, family support, skill training for people with developmental disabilities, and juvenile justice services.	One goal of the MSPPS is to develop community–based health navigation services that assist patients in scheduling appointments and obtaining community services. This includes services for people with

Mount Sinai Hospitals Group (PPS ID:34)

[Mount Sinai Hospitals Group] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing a wide range of services including special education, early childhood development, family support, skill training for people with developmental disabilities, and juvenile justice services.
71	LegalHealth, a division of the New York Legal Assistance Group	Provides free legal assistance to low-income New Yorkers with health problems in five New York burroughs.	One goal of the MSPPS is to develop community–based health navigation services that assist patients in scheduling appointments and obtaining community services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing legal assistance to low-income New Yorkers with health problems in five New York burroughs.
72	Long Island Consultation Center	This non-profit organization is an independent, private mental health center that strives to provide mental health and addiction services to all. The organization offers counseling, help with chemical dependency and mental health support.	One goal of the MSPPS is to integrate primary care services and behavioral health. This includes services for people with disabilities and special needs This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing mental health and addiction services to all. The organization offers counseling, help with chemical dependency and mental health support.
73	Lott Assisted Living Operating Corp.	The ALP and CHHA have an on-site relationship with cross-interdisciplinary use of case management, nursing and rehab services.	One goal of the MSPPS is to use the care transition model to reduce 30 day hospital readmissions for chronic health conditions through the use of community-based support services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing case management, nursing and rehab services.
74	Lott Community Home Health Care, Inc	An assisted living community that has a full-time on-site physician to provide preventative treatment.	One goal of the MSPPS is to create hospital-home care collaboration solutions. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was

Mount Sinai Hospitals Group (PPS ID:34)

[Mount Sinai Hospitals Group] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			engaged in the development of the MSPPS project, particularly in providing home health services through an assisted living community with a full-time on-site physicians to provide preventative treatment.
75	LSA Family Health Service, Inc.	This organization provides support through community programs including early intervention services, environmental health, educational and youth services, family support preventative services, home nursing, and parenting and childhood development.	One goal of the MSPPS is to develop community–based health navigation services that assist patients in scheduling appointments and obtaining community services. This includes services for people with disabilities and special needs This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing
76	Lutheran Social Services of New York (Children's Collaborative)	Enables children to reach their full potential through a full series of programs: church-affiliated services, food pantry and related services, senior support groups, legal services, and disaster case management.	One goal of the MSPPS is to develop community–based health navigation services that assist patients in scheduling appointments and obtaining community services. This includes services for people with disabilities and special needs This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing church-affiliated services, food pantry and related services, senior support groups, legal services, and disaster case management.
77	Madison Avenue Pharmacy	All aspects of pharmacy-related patient care	One goal of the MSPPS is to create an integrated delivery system that is community-based, and incorporates a full continuum of services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly in delivering all aspects of pharmacy related patient care.
78	Maranatha Human Services	Provides supportive services for New York City residents including Medicaid coordination, family care, day habilitation, skill-building for activities of daily living, Individualized Residential Alternatives, and a Family Support Program, among others.	One goal of the MSPPS is to create hospital-home care collaboration solutions. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly in providing supportive services including Medicaid coordination, , family care, day habilitation, skill-building for activities of daily living, Individualized Residential

Mount Sinai Hospitals Group (PPS ID:34)

[Mount Sinai Hospitals Group] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			Alternatives, and a Family Support Program, among others.
79	Martin de Porres Group Homes	These group homes provide youth with a stable environment and programs to help them develop skills and competencies to function more successfully in society. The homes encourage and strengthen existing family ties to help children successfully transition back into a home setting.	One goal of the MSPPS is to create an integrated delivery system that is community-based, and incorporates a full continuum of services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing youth with a stable environment and programs to help them develop skills and competencies to function more successfully in society. The homes help children successfully transition back into a home setting.
80	Mary Manning Walsh Home	Provide a full array of medical, rehabilitation, social service, discharge planning, home care and community based services.	One goal of the MSPPS is create hospital-home care collaboration solutions that provide care to patients through transition care management. This includes services for people with disabilities and special needs This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing a full array of medical, rehabilitation, social service, discharge planning, home care and community based services.
81	MedCare LLC	Provide interpretive services, educational, case management and others services that may be needed for our patients.	One goal of the MSPPS is to develop community–based health navigation services that assist patients in scheduling appointments and obtaining community services.. This includes services for people with disabilities and special needs This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing interpretive services, educational, case management and others services that patients require.
82	Methodist Home for Nursing and Rehabilitation	They provide residential nursing home care, short-term care/sub-acute outpatient rehabilitation services, respite care, palliative care, a stroke program, wound care program, medical oversight with hospice care and palliative care certification to maximize re-admission avoidance. They also offer a specialty program for residents with cognitive impairments.	One goal of the MSPPS is to create a care transition model to reduce 30 day hospital readmissions for chronic health conditions through the use of community-based support services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing residential nursing home care, short-

Mount Sinai Hospitals Group (PPS ID:34)

[Mount Sinai Hospitals Group] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			term care/sub-acute outpatient rehabilitation services, respite care, palliative care, a stroke program, wound care program, medical oversight with hospice care and palliative care certification to maximize re-admission avoidance. They also offer a specialty program for residents with cognitive impairments.
83	MHA-NYC	MHA-NYC operates a range of multilingual crisis services and has tools to promote the integration of behavioral health into primary care through ICBT with wrap-around supports. MHA-NYC is also the single point of access for Mobile Crisis Teams, operate NYC's only multilingual 24/7 crisis hotline and information and referral service, operates the statewide OASAS Hopeline Substance abuse and gambling disorders, operates centralized access and referral services for large provider networks, and has a suite of internet-based cognitive behavior therapy products. Our 5 Family Resource Centers and 4 Adolescent Skills Centers provide effective peer services that promote engagement and retention in services. We are also able to provide training and consultation to skilled nursing facilities on management of residents with behavioral health issues to prevent ED use and hospitalization.	One goal of the MSPPS is to integrate primary care services and behavioral health. This includes services for people with disabilities and special needs This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by operating a range of multilingual crisis services and promoting the integration of behavioral health into primary care through ICBT with wrap-around supports.
84	MZL Home Care Agency, LLC	They provide home care and assisted living for seniors with a variety of ability levels. They also provide case management, in-service/education, on-call support, and emergency/disaster preparedness protocols.	One goal of the MSPPS is to create hospital-home care collaboration solutions by matching services with transition care management. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing home care and assisted living for seniors with a variety of ability levels and providing case management and on-call support
85	National Association on Drug Abuse Problems, Inc. (NADAP, Inc.)	They provide care coordination, case management, assessments and referrals, vocational training, comprehensive employment services, IPA navigation, and insurance enrollment.	One goal of the MSPPS is to develop community-based health navigation services to assist patients in accessing community services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing care coordination, case management, assessments and referrals, vocational training, comprehensive employment services, IPA navigation, and insurance enrollment.

Mount Sinai Hospitals Group (PPS ID:34)

[Mount Sinai Hospitals Group] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
86	NAMI-NYC Metro	NAMI provides support, education, and advocacy for families and individuals of all ethnic and socioeconomic backgrounds who live with mental illness. Their programs include supports groups for friends, family, caregivers, and young adults; educational community seminars (for the public and for people living with mental illness); and legislative advocacy at the state and federal levels.	One goal of the MSPPS is to develop community-based health navigation services to assist patients in accessing community services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing support, education, and advocacy for families and individuals of all ethnic and socioeconomic backgrounds who live with mental illness. Their programs include supports groups for friends, family, caregivers, and young adults; educational community seminars (for the public and for people living with mental illness); and legislative advocacy at the state and federal levels.
87	Nassau Extended Care Facility	This skilled nursing facility offers an adult day care center, long-term care, and rehabilitation services.	One goal of the MSPPS is to reduce 30 day readmissions for chronic health conditions through a care transitions intervention model. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing adult day care, long-term care, and rehabilitation services.
88	Neighbors Home Care	This company matches home care workers with patients depending on the individual patient's need. They care for patients with a wide variety of ongoing illnesses or specialized needs.	One goal of the MSPPS is to create hospital-home care collaboration solutions by matching services with transition care management. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by matching home care workers with patients depending on the individual patient's need.
89	New Horizon Counseling Center	They provide social work, education, translation, case management and behavioral health services, enabling them to meet the triple aim of better care for individuals, better health for the population and lower costs through improvement.	One goal of the MSPPS is to create integrated delivery systems that are focused on evidence-based medicine and population health management. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing social work, education, translation,

Mount Sinai Hospitals Group (PPS ID:34)

[Mount Sinai Hospitals Group] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			case management and behavioral health services.
90	New York Congregational Nursing Center	A full service nursing center, with services including: palliative care, hospice care, and special wound care. Their complex Clinical Care includes IVs, PICC lines, trach care, bipap, and a pain management team, as well as a short term rehab and home visit prior to discharge in addition to CHHA referral. They also offer family support groups and resident discharge planning groups.	One goal of the MSPPS is to create hospital-home care collaboration solutions by matching services with transition care services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing patients with short-term rehab and a home visit prior to discharge.
91	New York Center For Rehabilitation & Nursing	A facility that offers short-term rehabilitation, long-term residential care, music therapy, long-term home health care, and HIV/AIDS care.	One goal of the MSPPS is to create integrated delivery systems that are focused on evidence-based medicine and population health management. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing social work, education, translation, case management and behavioral health services.
92	New York Congregational Nursing Center	A full service nursing center, with services including: palliative care, hospice care, and special wound care. Their complex Clinical Care includes IVs, PICC lines, trach care, bipap, and a pain management team, as well as a short term rehab and home visit prior to discharge in addition to CHHA referral. They also offer family support groups and resident discharge planning groups.	One goal of the MSPPS is to create hospital-home care collaboration solutions by matching services with transition care services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing patients with short-term rehab and a home visit prior to discharge.
93	New York Psychotherapy and Counseling Center	The Center encompasses several mental health centers for children and adults, continuing day treatment programs, programs for adult home residents, and a larger mental health treatment program.	One goal of the MSPPS is to integrate primary care and behavioral health. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing mental health treatment of children
94	Northside Center for Child Development	This center encompasses mental health clinic care for children, families, and adults at six clinic locations in Harlem – four of which are located in Harlem-area schools. They also provide day treatment for children, home-based clinic Intervention, preventive service programs, after-school, tutoring, and head-start programs for children.	One goal of the MSPPS is integrate primary care and behavioral health. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing

Mount Sinai Hospitals Group (PPS ID:34)

[Mount Sinai Hospitals Group] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			mental health clinics that include day treatment for children, home-based clinic intervention, preventive service programs, after-school, tutoring, and head-start programs for children.
95	ODA Primary Health Care Network	Primary care and specialty care including: pediatrics, internal medicine, cardiology, gastroenterology, nutrition counseling, social work, pediatric neurology, obstetrics, gynecology, podiatry, ophthalmology, Speech Therapy, and Interpretation Services.	One goal of the MSPPS is to create integrated delivery systems that are focused on evidence-based medicine and population health. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing primary care and specialty care including: pediatrics, internal medicine, cardiology, gastroenterology, nutrition counseling, social work, pediatric neurology, obstetrics, gynecology, podiatry, ophthalmology, speech therapy, and interpretation services.
96	Odyssey House, Inc.	Odyssey House offers a range of behavioral and primary health care services to patients, in addition to transitional and permanent supportive housing. Our services are tailored to specific populations. They offer residential and outpatient substance use disorder treatment programs for adolescents (outpatient only), pregnant and post-partum women, transition age youth, adults, older adults, and parolees. In addition, our housing programs serve people with a substance use disorder, people with a serious mental illness, and people with HIV/AIDS. Odyssey House also operates a DOH-licensed Article 28 diagnostic and treatment center.	One goal of the MSPPS is integrate primary care and behavioral health. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing behavioral and primary health care services to patients, in addition to transitional and permanent supportive housing.
97	Outreach Development Corp.	Chemical dependency outpatient services, adolescent residential services, day treatment services for women and women with children. Day treatment for adolescents are provided by social workers, CASACs and other QHPs. Services are provided in English and Spanish in Queens facilities, and in English, Spanish & Polish in Outreach's Greenpoint, Brooklyn unit.	One goal of the MSPPS is to integrate primary care services and behavioral health. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing chemical dependency outpatient services, adolescent residential services, day treatment services for women and women with children. Services are provided in multiple languages.
98	Oxford Nursing Home	Besides providing physical, occupational, and speech therapy, they proved skilled nursing care, palliative care, and short-term rehab. Our social workers arrange services in the community to allow for a safe discharge. All discharges reviewed by an experienced RN who checks what measures were taken in the hospital. The assessment is conducted to determine whether the hospitalizations.	One goal of the MSPPS is to create hospital-home care collaboration solutions by matching services with transition care management. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in

Mount Sinai Hospitals Group (PPS ID:34)

[Mount Sinai Hospitals Group] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			the development of the MSPPS project, particularly by providing ensuring that social workers and RNs work together to arrange services in the community to allow for a safe discharge.
99	Parker Jewish Institute for Health Care and Rehabilitation	Non-profit health care center intended for the care, rehabilitation, and health education of adults, as well as an academic campus for health care professionals. They offer social work, case management, translation, and transitional care support.	One goal of the MSPPS is to develop community-based health navigation services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing patients with social work, case management, translation, and transitional care support
100	Peninsula Nursing and Rehabilitation	Nursing home that also offers adult day health care, clinical lab service, and diagnostic radiology services in addition to 24-hour nursing care, supplies, and equipment.	One goal of the MSPPS is to create integrated delivery systems that are focused on evidence based medicine and population health management. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing adult day health care, clinical lab service, and diagnostic radiology services in addition to 24-hour nursing care, supplies, and equipment.
101	Phoenix House	Continuum of substance abuse services and addiction medicine.	One goal of the MSPPS is to integrate primary care services and behavioral health. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing a continuum of substance abuse services and addiction medicine.
102	Planned Parenthood of New York City, Inc.	Planned Parenthood of New York City (PPNYC) has four reproductive health centers that provide the full range of reproductive health services, as well as educational programming for youth and adults. PPNYC's Project Street Beat program provides comprehensive, street-based HIV prevention and access-to-care services to HIV+ and high-risk individuals living in underserved neighborhoods in the Bronx, Brooklyn, and Northern Manhattan. The program provides linkage to and retention in HIV primary care services and behavioral health services (at partnering providers).	One goal of the MSPPS is to increase early access to, and retention in, HIV care. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing comprehensive, street-based HIV prevention and access-to-care services to HIV+ and high-risk individuals living in underserved neighborhoods in the Bronx, Brooklyn, and Northern Manhattan. The program provides linkage to and

Mount Sinai Hospitals Group (PPS ID:34)

[Mount Sinai Hospitals Group] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			retention in HIV primary care services and behavioral health services (at partnering providers).
103	Premier HealthCare (PHC)	This is an ACO that provides integrated primary care and behavioral health services.	One goal of the MSPPS is to integrate primary care services and behavioral health. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by following the integrated primary care/behavioral health service model.
104	Puerto Rican Family Institute, Inc.	PRFI is a not-for-profit, multi-program, family-oriented health and human service agency that provides culturally sensitive services to all children, youth, adults and families. PRFI's core services include outpatient mental health clinics, domestic violence services, case management programs, residential care, crisis intervention, HIV/AIDS prevention and education, and Head Start programs in the Bronx and Brooklyn. It also provides New York State's largest case management program.	One goal of the MSPPS is to create an integrated delivery systems that are focused on evidence based medicine and population health management. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing culturally sensitive services to all children, youth, adults and families. PRFI's core services include outpatient mental health clinics, domestic violence services, case management programs, residential care, crisis intervention, HIV/AIDS prevention and education, and Head Start programs in the Bronx and Brooklyn. It also provides New York State's largest case management program.
105	QSAC, Inc. (Advance Care Alliance Member Agency)	QSAC is a New York City and Long Island based nonprofit that supports children and adults with autism, together with their families, in achieving greater independence, realizing their future potential, and contributing to their communities in a meaningful way by offering person-centered services. They administer direct services that provide a supportive and individualized setting for children and adults with autism to improve their communication, socialization, academic, and functional skills.	One goal of the MSPPS is to integrate primary care services and behavioral health. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by offering person-centered services to children and adults with autism.
106	Queens Boulevard Extended Care Facility	Queens Boulevard is a 280-bed nursing facility that offers short- and long-term care, case management, education, and social work services.	One goal of the MSPPS is to use the care transitions intervention model to reduce 30 day readmissions for chronic conditions. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing short- and long-term care, case management, education, and

Mount Sinai Hospitals Group (PPS ID:34)

[Mount Sinai Hospitals Group] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			social work services.
107	Queens Nassau Rehab and Nursing Center	Queens Nassau Rehabilitation and Nursing Center provides intensive rehabilitation therapy services intended to return brain injury patients back to the community with independence. They operate as part of the state's Certified TBI Program, which is set apart from generic rehabilitation programs by providing specialized psychiatry services, cognitive re-training, and neuropsychological testing. Additionally, physical, occupational, and speech therapy are also specialized towards brain injury rehabilitation.	One goal of the MSPPS is to create integrated delivery systems that are focused on evidence-based medicine and population health management. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing offers a comprehensive range of evidence-based services, including mental health and substance abuse treatment, housing, vocational training and job placement, health care, education and creative arts therapies.
108	Queens Parent Resource Center	Through family support services, QPRC provides services including planned in-home respite, after-school respite, family reimbursement and outreach. Medicaid-provided services include service coordination, residential habilitation, and in-home respite.	One goal of the MSPPS is to develop community-based health navigation services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing planned in-home respite, after-school respite, family reimbursement and outreach. Medicaid-provided services include service coordination, residential habilitation, and in-home respite.
109	Queens-Long Island Renal Institute	QLRI is a dialysis center in Queens and Long Island. It offers an interdisciplinary team of experienced nephrologists, dialysis registered nurses, a renal social worker, and a renal dietician.	One goal of the MSPPS is to increase access to high quality chronic disease preventative care and management in both clinical and community settings. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing patients with an interdisciplinary team of experienced nephrologists, dialysis registered nurses, a renal social worker, and a renal dietician.
110	Regency Extended Care Center	Regency Extended Care Center is a 315 bed facility in Yonkers offering modern, compassionate short and long-term care and rehabilitation to people who are elderly, convalescent, handicapped, or chronically ill.	One goal of the MSPPS is to use the care transitions model to reduce 30 day readmissions for chronic health conditions. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing short and long-term care

Mount Sinai Hospitals Group (PPS ID:34)

[Mount Sinai Hospitals Group] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			and rehabilitation to people who are elderly, convalescent, handicapped, or chronically ill.
111	Ridgewood Bushwick Senior Citizens Council	Ridgewood offers a variety of services including case management, home delivered meals, congregate meals, health-related workshops, supportive housing services and translations as needed. They also provide physical education via yoga, tai-chi and dancing instruction.	One goal of the MSPPS is to develop community-based health navigation services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing case management, home delivered meals, congregate meals, health-related workshops, supportive housing services and translations as needed.
112	Road 2 Recovery	Operated by the Bridge, R2R targets Bridge residential patients who have been chronically homeless or had long stays in State psychiatric or correctional facilities. It provides clients with an introductory readiness experience prior to participating in more formal recovery programs such as PROS or supported employment.	One goal of the MSPPS is to develop community-based health navigation services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing introductory readiness experience prior to participating in more formal recovery programs such as PROS or supported employment.
113	Rockaway Care Center	Rockaway is a skilled nursing center that offers ventilator services, hospice care, and rehabilitation services.	One goal of the MSPPS is to use the care transitions model to reduce 30 day readmissions for chronic health conditions. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing rehabilitative services.
114	Schervier Nursing Care Center	They are a full service 364-bed skilled nursing facility, as well as a long term home health care program and a certified home health care agency. In addition, Schervier is a founding member of Cardinal Health Partners IPA and as such provides care management on a capitated basis. Schervier has centers of excellence including Alzheimer's and palliative care as well as a care transitions program and low income senior housing.	One goal of the MSPPS is to develop hospital-home care solutions by matching services with transition management. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by offering home health care and care transitions programs.
115	SCO Family of Services	SCO offers person-centered services tailored to meet individual needs at home, in school and in the community. Their clinicians and caseworkers provide expert assessment, care coordination, harm reduction and symptom and behavior management for children and youth, young adults and families with	One goal of the MSPPS is to develop hospital-home care solutions by matching services with transition management. This includes services for people with disabilities and special needs. This organization

Mount Sinai Hospitals Group (PPS ID:34)

[Mount Sinai Hospitals Group] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		complex mental health, developmental, medical and substance abuse needs.	responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing person-centered services tailored to meet individual needs at home, in school and in the community. Their clinicians and caseworkers provide expert assessment, care coordination, harm reduction and symptom and behavior management for children and youth, young adults and families with complex mental health, developmental, medical and substance abuse needs.
116	Sephardic Nursing & Rehabilitation Center	Sephardic offers patient and family education, social service supports, and case management.	One goal of the MSPPS is to develop community-based health navigation services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing patient and family education, social service supports, and case management.
117	Settlement Health	Settlement Health offers care/case management, on-site translation, facilitated insurance enrollment, and patient-centered, integrated care.	One goal of the MSPPS is to develop community-based health navigation services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing care/case management, on-site translation, facilitated insurance enrollment, and patient-centered, integrated care.
118	Sheepshead Nursing and Rehabilitation Center LLC	Located in Brooklyn, Sheepshead offers patient-centered care. That includes case management, utilization review, translation, rehabilitation services, PT, OT, and ST.	One goal of the MSPPS is to use the care transitions intervention model to reduce 30 day readmissions for chronic health conditions. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly providing case management, utilization review, translation, rehabilitation services, PT, OT, and ST.
119	Spring Creek Rehabilitation	Located in Brooklyn, Spring Creek is a nursing facility with 188 beds.	One goal of the MSPPS is to use the care transitions intervention model to reduce 30 day readmissions for chronic health conditions. This

Mount Sinai Hospitals Group (PPS ID:34)

[Mount Sinai Hospitals Group] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly providing nursing facility services.
120	St. Christopher's Inn	St. Christopher's Inn provides a truly integrated model of care. They provide meals, shelter, substance use disorder treatment, primary care and behavioral health treatment.	One goal of the MSPPS is to integrate primary care services and behavioral health. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing a truly integrated model of care. They provide meals, shelter, substance use disorder treatment, primary care and behavioral health treatment.
121	St. Vincent de Paul Skilled Nursing and Rehab Center	Located in the Bronx, St. Vincent de Paul is operated by the Continuing Care Community of the Archdiocese of New York, serves the Latino community. They operate an assisted living program as well as a PACE Center.	One goal of the MSPPS is to use the care transitions intervention model to reduce 30 day readmissions for chronic health conditions. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly providing an assisted living program as well as a PACE center.
122	Steinway Child and Family Services, Inc.	Steinway is a non-profit agency dedicated to providing comprehensive, quality human services. Their programs operate in nine community-based clinics. Clinic referrals come from community groups, schools, managed care providers, residential centers, faith-based institutions, hospitals, drug/alcohol programs, mobile crisis teams, provider agencies, New York City and State mental health and social services agencies and former and current clients.	One goal of the MSPPS is to develop community-based health navigation services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing comprehensive human services.
123	SUNY - UNIVERSITY EYE CENTER	The UEC is one of the largest vision care clinics in the country, with approximately 70,000 patient visits annually. Services include adult and pediatric primary vision care, advanced care, rehabilitation, diabetic eye care, eyewear, and social services.	One goal of the MSPPS is to use evidence based strategies for disease management in patients who are high risk/effected by diabetes. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing diabetic eye care.
124	The Bridge	The Bridge offers a comprehensive range of evidence-based services, including mental health and substance abuse treatment, housing, vocational training and job placement, health care, education	One goal of the MSPPS is to create integrated delivery systems that are focused on evidence-based medicine and population health management.

Mount Sinai Hospitals Group (PPS ID:34)

[Mount Sinai Hospitals Group] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		and creative arts therapies.	This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing offers a comprehensive range of evidence-based services, including mental health and substance abuse treatment, housing, vocational training and job placement, health care, education and creative arts therapies.
125	The Brooklyn Hospital Center	TBHC has a recently developed Health Situation Room, an innovative program to analyze community need and shape strategic interventions. TBHC has achieved PCMH recognition in most of the Article 28 clinics, and operates ambulatory care pharmacotherapy clinics to improve medication adherence and reduce risk of readmissions. THBC is a participant of the HMH demonstration, which fostered the development of population health and care transition management.	One goal of the MSPPS is to use the care transitions model to reduce 30 day hospital readmissions for chronic health conditions. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by improving medication adherence and working to reduce the risk of readmissions. THBC is a participant of the HMH demonstration, which fostered the development of population health and care transition management.
126	The Children's Aid Society	Children's Aid serves New York's neediest children and their families at more than 40 locations in the five boroughs and Westchester County. Their services include prenatal counseling and assistance, college and job preparatory training programs. Additionally, a host of services are available to parents, including housing assistance, domestic violence counseling, and health care access.	One goal of the MSPPS is to develop community-based health navigation services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing children and their families with prenatal counseling and assistance, college and job preparatory training programs, housing assistance, domestic violence counseling, and health care access.
127	The Children's Village	The Children's Village specializes in caring for children with complex health care needs, including psychiatric and behavioral illness. They provide comprehensive social work, psychiatric and medical care services.	One goal of the MSPPS is to integrate primary care services and behavioral health. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing comprehensive social work, psychiatric and medical care services to children with complex health care needs.
128	The Dennelisse Corporation	The Dennelisse Corporation offers family support	One goal of the MSPPS is to develop

Mount Sinai Hospitals Group (PPS ID:34)

[Mount Sinai Hospitals Group] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		services (e.g., child care), case management and training staff training services.	community-based health navigation services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing family support services (e.g., child care), case management and training staff training services.
129	The Fifth Ave counseling Center	The Fifth Avenue Center is a not-for-profit, outpatient mental health center. Their multidisciplinary team offers individual, couples, family and group psychotherapy to patients with a wide variety of diagnoses. A dedicated staff of over forty clinical social workers, psychologists and psychiatrists provide talk therapy and medication management.	One goal of the MSPPS is to implement an evidence based medication adherence program in community-based sites for behavioral health medication compliance. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing patients with social workers, psychologists and psychiatrists provide talk therapy and medication management.
130	The Komanoff Center for Geriatric and Rehabilitative Medicine	The Komanoff Center is a nursing home that offers baseline services, and has 150 beds.	One goal of the MSPPS is to use the care transitions model to reduce 30 day hospital readmissions for chronic health conditions. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by offering rehabilitative baseline services.
131	The PAC Program (Power and Control)	The PAC Program provides quality, individualized, and patient centered addiction treatment. Services include outpatient drug and alcohol treatment, co-occurring (mental health and addiction) programs, DUI assessment and treatment, and anger management programs.	One goal of the MSPPS is to integrate primary care services and behavioral health. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing individualized, and patient centered addiction treatment. Services include outpatient drug and alcohol treatment, co-occurring (mental health and addiction) programs, DUI assessment and treatment, and anger management programs.
132	Throgs neck Extended care Facility	Located in the Bronx, is a skilled nursing facility. They offer specialized care, short and long term rehabilitation, and unique medical, nursing and rehabilitative programs.	One goal of the MSPPS is to use the care transitions model to reduce 30 day hospital readmissions for chronic health conditions. This includes

Mount Sinai Hospitals Group (PPS ID:34)

[Mount Sinai Hospitals Group] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing specialized care, short and long term rehabilitation, and unique medical, nursing and rehabilitative programs.
133	Tri Care Systems DBA Long Island Association for AIDS Care	Tri Care Systems operates in an integrated health care delivery system, utilizing both medical and behavioral evidence based models. It is community-based and operates through established collaborations with support organizations in Queens, Suffolk and Nassau country. These organizations include: primary health care facilities and health centers, substance abuse treatment centers, mental health organizations, hospitals, and community agencies.	Two goals of the MSPPS are to (1) integrate primary care services and behavioral health and (2) to increase early access to, and retention in, HIV care. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing an integrated health care delivery system, utilizing both medical and behavioral evidence based models. It is community-based and operates through established collaborations with support organizations in Queens, Suffolk and Nassau country. These organizations include: primary health care facilities and health centers, substance abuse treatment centers, mental health organizations, hospitals, and community agencies.
134	Union Settlement Association	Union Settlement is a multi-generational social service provider. Their programs include early childhood education, youth development, adult education, mental health counseling and senior services. Wellness activities are an integral part of all of their programs, including but not limited to their senior centers, social adult day care center, Meals on Wheels, Teen Health Project and others.	One goal of the MSPPS is to develop community-based health navigation services. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing social services including: childhood education, youth development, adult education, mental health counseling, and senior services. Wellness activities are an integral part of all of their programs, including but not limited to their senior centers, social adult day care center, Meals on Wheels, Teen Health Project and others.
135	University Consultation Center (Coordinated Behavioral Care IPA Network Member Agency)	Located in the Bronx, the Center is a behavioral health organization that provides clinical, rehabilitative, residential, case management, and support services to special needs populations.	One goal of the MSPPS is to integrate primary care services and behavioral health. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of

Mount Sinai Hospitals Group (PPS ID:34)

[Mount Sinai Hospitals Group] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			the MSPPS project, particularly by providing clinical, rehabilitative, residential, case management, and support services to special needs populations.
136	Venture House (Coordinated Behavioral Care IPA Network Member Agency)	The Clubhouse provides rehabilitation services to people who have been diagnosed with a mental health illness. Their recovery focused set of supports and services aims to further independence, encourages engagement, and reduction of isolation. It is open every day of the year.	One goal of the MSPPS is to integrate primary care services and behavioral health. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing rehabilitation services to people who have been diagnosed with a mental health illness.
137	Village Center for Care	VillageCare is a community-based, not-for-profit organization serving people with chronic care needs, as well as seniors and individuals in need of continuing care and rehabilitation services. They offer a comprehensive array of community and residential programs for persons in need of rehabilitation, long-term care and medical services, and for those living with HIV/AIDS.	One goal of the MSPPS is to use the care transitions model to reduce 30 day hospital readmissions for chronic health conditions. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing continuing care and rehabilitation services to patients with chronic care needs.
138	VIP Community Services	Located in the Bronx, the Vocational Instruction Project (VIP), is a safe place where individuals can get help with their addiction, learn a vocation or trade, and get back on their feet. They serve approximately 25,000 clients and patients per year through residential care, outpatient counseling, shelter care, medical services, medically supervised intervention programs, housing, and employment services.	One goal of the MSPPS is to integrate primary care services and behavioral health. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing residential care, outpatient counseling, shelter care, medical services, medically supervised intervention programs, housing, and employment services.
139	Visiting Nurse Service of NY	The Visiting Nurse Service of New York is the largest not-for-profit home health care agency in the United States, with more than 17,000 employees, including 11,718 certified home health aides and home attendants. They offer a comprehensive array of home- and community-based services, programs and health plans to meet the diverse medical and personal care needs of our patients, members and clients, regardless of age, diagnosis or ability to pay. On any given day, they serve more than 35,000 patients in all five boroughs of New York City, as well as in Nassau, Suffolk, and Westchester Counties and parts of upstate New York.	One goal of the MSPPS is to develop hospital-home care solutions by matching services with transition management. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing a comprehensive array of home- and community-based services, programs and health plans to meet the diverse medical and personal care needs of our patients, members and clients, regardless of age, diagnosis or ability to pay.

Mount Sinai Hospitals Group (PPS ID:34)

[Mount Sinai Hospitals Group] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
140	William F Ryan Community Health Center, Inc.	The Center is a federally qualified health center located in Manhattan. Ryan provides a variety of services, including adult medicine, pediatrics, women's health, adolescent health, geriatrics, dental, behavioral health, nutrition, an array of specialty services, Women, Infant, and Children (WIC), health education, HIV services, home visits when necessary, and transportation when medically indicated.	Two goals of the MSPPS are to (1) integrate primary care services and behavioral health and (2) to increase early access to, and retention in, HIV care. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing adult medicine, pediatrics, women's health, adolescent health, geriatrics, dental, behavioral health, nutrition, an array of specialty services, Women, Infant, and Children (WIC), health education, HIV services, home visits when necessary, and transportation when medically indicated.
141	Woodmere Rehabilitation and Health Care Center	Woodmere is a 336-bed skilled nursing facility located in the residential "Five Towns" section of Nassau County. The Woodmere Rehabilitation and Health Care Center emphasizes an interdisciplinary approach towards attaining quality outcomes for a variety of diagnoses. Rehabilitation disciplines including physical and occupational therapies, speech-language pathology, therapeutic recreation, social services, and nursing work together to achieve maximum independence for the residents they serve.	One goal of the MSPPS is to use the care transitions model to reduce 30 day hospital readmissions for chronic health conditions. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing physical and occupational therapies, speech-language pathology, therapeutic recreation, social services, and nursing work together to achieve maximum independence for the residents they serve.
142	Woodmere Rehabilitation and Health Care Center	Woodmere is a 336-bed skilled nursing facility located in the residential "Five Towns" section of Nassau County. The Woodmere Rehabilitation and Health Care Center emphasizes an interdisciplinary approach towards attaining quality outcomes for a variety of diagnoses. Rehabilitation disciplines including physical and occupational therapies, speech-language pathology, therapeutic recreation, social services, and nursing work together to achieve maximum independence for the residents they serve.	One goal of the MSPPS is to use the care transitions model to reduce 30 day hospital readmissions for chronic health conditions. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and was engaged in the development of the MSPPS project, particularly by providing physical and occupational therapies, speech-language pathology, therapeutic recreation, social services, and nursing work together to achieve maximum independence for the residents they serve.
143	Young Adult Institute (YAI)	The organization offers coordinated primary and specialty health care, evaluations, early intervention, workplace training and placement for people living with disabilities, social support,	One goal of the MSPPS is to integrate primary care services and behavioral health. This includes services for people with disabilities and special needs. This organization responded to the MSPPS survey and

Mount Sinai Hospitals Group (PPS ID:34)

[Mount Sinai Hospitals Group] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			was engaged in the development of the MSPPS project, particularly by providing coordinated primary and specialty health care, evaluations, early intervention, workplace training and placement for people living with disabilities, social support….

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.

[Mount Sinai Hospitals Group] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
1	Lack of access to social services	There is a scarcity of food pantries in three of the six regions compared to the low income and homeless populations living in those areas.	Health Information Tool for Empowerment SITE, 2014
2	Increase access to specialty care services	61% of survey respondents report Medicaid beneficiaries have a difficult time accessing specialty care services.	Mount Sinai PPS Community Needs Assessment Survey #1, 2014
3	Shortage of mental health services	Mental health has HPSA designations all six regions with 59 designations combined. 68% of survey respondents indicated Medicaid beneficiaries have a "Difficult" or "Very Difficult" time accessing mental health services.	Health Professional Shortage Areas, Mount Sinai PPS Community Needs Assessment Survey #1, 2014
4	Shortage of primary care services	Primary medical care has the largest number of HPSA designations in the six service areas combined with 69 designations.	Health Professional Shortage Areas
5	Shortage of dental care services	Dental care has HPSA designations all six regions with 54 designations combined.	Health Professional Shortage Areas
6	Lack of community health centers	Queens and Staten Island are underserved for health care centers, which are a key access point for low-income residents for primary and preventive care.	HRSA Site Directory, Kaiser Family Foundation, 2011
7	Need for more care coordination	Barriers to care coordination as identified by providers include: lack of physician training, current	Mount Sinai PPS Community Needs

Mount Sinai Hospitals Group (PPS ID:34)

[Mount Sinai Hospitals Group] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		delivery system operating in "silos," and lack of IT infrastructure to promote effective communication and coordination.	Assessment Survey #1, 2014
8	Need to increase behavioral health services for children and adolescents	There is a significant lack of facilities that serve adolescents and children. There are only 141 behavioral health facilities that serve children and adolescents versus almost 1000 dedicated to adults.	Adult Medicaid Utilization & Expenditures for Region of Provider for Local Fiscal Year 2013, OMH
9	Need for more education about the underlying causes of diabetes	Public health survey data suggests the underlying causes of type 2 diabetes (including obesity, physical inactivity, and poor diet) are not being addressed effectively.	New York City, EpiQuery Survey Data, 2012 data.
10	Need for better diabetes management	New York City has higher diabetes mortality rates than New York state. It is also the leading cause of premature deaths in the city. One in ten Medicaid enrollees in New York City have some form of diabetes. There is a significant need to address diabetes complications in New York City.	New York State Department of Health Number of Diabetes Mellitus, 2012 data, NY Prevention Agenda Dashboard, 2012
11	Improve infant and maternal health	Maternal mortality rates among Medicaid women in New York City are higher than the state average. The percentage of children aged 0-15 months who have had the recommended number of well child visits is lower in New York City than the state.	New York State Department of Health HEDIS Measures, 2012 data.
12	Need for more education, resources and promotion of healthy lifestyles	One in four adults are obese in New York City. One in five New Yorkers are smokers. Staten Island has the highest proportion of adults who smoke (20%) compared to the state average (17%).	2008-2009 NYS Expanded Behavioral Risk Factor Surveillance System Data as of 2010, Percentage of Adults that are Obese (BMI 30 or Higher), 2008-2009 NYS Expanded Behavioral Risk Factor Surveillance System Data as of 2010, Age-adjusted Percentage of Adults who Smoke Cigarettes.
13	Necessity of patient navigation, including patient engagement and education.	The leading cause behind challenges to accessing care among all provider types was reported as patient difficulty navigating the system and a lack of awareness of available resources for patients.	Mount Sinai PPS Community Needs Assessment Survey #1, 2014
14	Lack of patient follow up after hospital discharge	New York City performs the worst in the state for ensuring that there is an ambulatory follow-up with seven days of discharge.	Office of Performance Measurement and Evaluation, BHO Databook, CY2012
15	Need to improve quality of nursing homes in the Mount Sinai service area	Half of the nursing homes in three of the six regions are performing below the state average in terms of proper levels of care and monitoring for depressive symptoms and pain management.	NYDOH Nursing Home Profiles, 2014
16	Need to increase number of providers who participate in a Health Information Exchange (HIE)	Only one third of survey respondents reported participating in a HIE.	Mount Sinai PPS IT Readiness Assessment Survey, 2014 data
17	Need to increase number of providers who accept Medicaid coverage	Manhattan has the largest number of physicians as well as the lowest percentage of physicians who accept Medicaid with only 40% of physicians	New York State Doctor Profile, 2014

Mount Sinai Hospitals Group (PPS ID:34)

[Mount Sinai Hospitals Group] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		accepting Medicaid patients.	
18	Higher mortality rates for AIDs, pneumonia, diabetes, and homicide	There are higher mortality rates in the Mt. Sinai service area for AIDs, pneumonia, diabetes, and homicide when compared to New York state.	NY Vital Statistics, 2012
19	Higher prevalence of cardiovascular conditions	30% of the 3.5 million Medicaid enrollees in New York City have a cardiovascular disease or disorder.	New York State Department of Health, Number of Medicaid Beneficiaries with Disease and Disorders of the Cardiovascular System, 2012, Number of Medicaid Enrollees (including duals), 2012 data
20	Higher preventable hospital admissions due to cardiovascular conditions	New York City has a higher rate of preventable hospital admissions for cardiovascular conditions than New York state based on the measures for PQI #7 and PQI #13.	New York State Department of Health, Adult Hypertension (PQI #7) Admissions per 100,000 Recipients, 2011-12 data, Adult Angina without Procedure (PQI #13) Admissions per 100,000 Recipients, 2011-12 data
21	Higher prevalence of asthma	64% of reported asthma diagnoses among Medicaid beneficiaries in New York state live in the New York City region. New York City has a higher rate of preventable hospital admissions due to asthma compared to New York State.	New York State Department of Health, Medicaid Chronic Conditions, Inpatient Admissions and Emergency Room Visits by Zip Code: Beginning 2012, 2012 Data, New York State Department of Health, Statewide Planning and Research Cooperative System (SPARCS), 2012 data
22	Higher HIV prevalence and incidence	Of the 53,901 Medicaid beneficiaries living with HIV in New York State, 49,984, or 93%, live in New York City. New York City HIV incidence rate per 100,000 is almost double the New York State rate.	New York State Department of Vital Statistics, 2012 data, New York State HIV/AIDS Surveillance Annual Report, 2012, New York State Department of Health, 2012 data, New York Prevention Agenda Dashboard, 2012 data
23	Higher case rates of gonorrhea and syphilis	The case rate of gonorrhea for males in New York City is almost double the case rate of New York State. Case rates of gonorrhea for women in New York city are higher than the state rate. Syphilis rates in New York City are almost eight times as high as the state for late and early syphilis.	Matt Baney, Mount Sinai Director, Institute for Advanced Medicine, NY State Rate per 100,000 Population by Disease and County: Strep Group

Mount Sinai Hospitals Group (PPS ID:34)

[Mount Sinai Hospitals Group] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
			B Invasive - Vibrio Non-Cholera, 2011

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
34_SEC038_MSPPS CNA (12.22.14).pdf	12/22/2014 02:34:11 PM	

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

DSRIP PPS Organizational Application

Mount Sinai Hospitals Group (PPS ID:34)

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: **Mt Sinai_Section4_Text_DSRIP Project Plan Application _ Section 4.Part I(text).12.10.14_MSPPS_final.docx**

Description of File

Alternative versions of 2.b.iv, 3.a.iii, and 3.b.i are attached in section 3.4 per instructions.

File Uploaded By: mssl1212

File Uploaded On: 12/22/2014 02:17 PM

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

Currently Uploaded File: **Mt Sinai_Section4_ScopeAndScale_Mount Sinai PPS_DSRIP Project Plan Application _Scale & Speed UPDATED _ 12.21.14 1030am.xlsx**

Description of File

File Uploaded By: mssl1212

File Uploaded On: 12/22/2014 11:49 AM

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

DSRIP PPS Organizational Application

Mount Sinai Hospitals Group (PPS ID:34)

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.

As the PPS builds an integrated delivery system, a key strategic imperative is transforming the underlying workforce. Across the PPS, our workforce exceeds 71,400 workers. Beyond the 37,000 MSHS employees, thousands of whom will be participating directly or indirectly on projects, we anticipate an additional 20,416 employees from partner organizations will be engaged in projects. Of these, roughly 74% are providing direct clinical care to patients, while 26% are providing supportive and operational services. Paraprofessional workers comprise 58% of the staff providing direct patient care and services, registered nurses (RNs) 13%, and nurse practitioners (NPs) 6%. Of our current vacancies, 45% are for paraprofessional positions, 15% for RNs and 8% for specialty physicians. Of the operations and administrative staff, who support clinical staff, 11% are nearing retirement (62 or older), 30% are unionized, and 49% are administrative and clerical staff.

Mount Sinai Hospitals Group (PPS ID:34)

The overall PPS workforce strategy is to align training, retraining, recruitment and redeployment initiatives to the clinical needs of the PPS. We conducted surveys to understand our partners current staffing and anticipated workforce needs and based on this data, we anticipate retraining about 12,000 existing staff and redeploying at least 600. Worker classifications were identified that will require training include certified nursing assistants (CNAs), licensed nurses (LNs), RNs, social workers (SWs), and primary care physicians (PCPs). Our partners also ranked highly the need to redeploy RNs, MDs, NPs, physician assistants (PAs), SWs, and clerical staff. Based on survey data and internal planning, we anticipate hiring an additional 1,435 workers who would include case managers, psychiatrists, psychologists, SWs, as well as clinical and operational staff for the MSO. Other areas where we anticipate growth include community health workers and patient navigators, as required in Project 2.c.i.

Workers in existing practices and facilities will need to adopt new skills and all training will provide context to engage the workforce in the overarching vision for DSRIP and project goals. Moreover, frontline supervisors and care providers must work collaboratively to create systems where patients and their families are the central focus. This requires new ways of working within existing settings and across new partnerships, as unit-based care teams are deployed to support patients and manage population health in acute, post-acute, and community settings.

As facilities are revamped and developed, we will need to hire additional staff to ensure appropriate staffing levels. Some of these positions may be similar to existing jobs (e.g., staffing for new clinics and urgent care centers), and new jobs will be created, including community health workers, patient educators, and social work assistants, among others.

We anticipate the following professions will have the greatest need for redeployment: CNAs, LNs, RNs, SWs, and PCPs. Additionally, our goal to reduce overall bed capacity will result in staff reductions of between four and seven people per bed reduction. This may mean additional impacts not only in the categories listed above, but also on housekeeping, food services, and transportation workers. These job classifications are of critical importance to managing population health collectively within the PPS.

The 1199SEIU Training and Employment Funds (TEF) has been retained to provide high-level strategic workforce services. TEF will serve in a lead coordinating capacity to achieve economies of scale and ensure that high quality training and education vendors are recommended and secured for the MSO. They will also support recruitment, pre-training screening, and wrap-around case management services to increase participant retention and completion of training programs.

***Strategy 2:**

In the response, please include

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

The alignment of labor and management within the PPS and its partners is critical in minimizing the negative impact to the workforce. We will work collectively to identify new and/or changing job functions and communicate with the workforce about the impact of those changes and the resources that will be available to ease the transition. Labor-Management Partnerships will be key to ensuring worker engagement and support.

Given the complexity and number of the types of workers that may need to be retrained, redeployed, or newly hired, it is imperative that MSPPS works with our partner providers, labor unions such as 1199SEIU and NSYNA, and training programs (e.g., TEF and local community colleges). Our labor union and training program partners have decades of experience working with many of the providers in our PPS to redeploy and retrain workers, and are critical to minimizing disruptions to the rest of the workforce.

There will be an institutional needs assessment, as appropriate for each affected partner and/or unit. The assessment will identify timing and the number of workers impacted, including the number of workers in need of retraining; the number of vacancies that are anticipated and skill sets required.

Across our network, there are more than 3,000 current vacancies. Of these, 70% are patient facing, clinical roles. Of patient facing position vacancies, 39% require CNAs and other patient care paraprofessionals and 22% are for RNs. Additionally, 29% of the vacancies are for non-patient facing roles, for which the greatest need is additional administrative staff.

Mount Sinai Hospitals Group (PPS ID:34)

These vacancies are in part due to a number of current recruitment challenges. Our partners cited environmental, geographic, economic, and workforce factors that make it difficult to find and hire staff. These challenges include non-competitive wages and benefits, strong competitions in the region, labor shortages, rigorous job qualifications limiting potential candidate pool, preference of qualified applicants for working outside of the region, lack of knowledge of certain types of jobs, and workers not sufficiently prepared by schools to work in these positions.

Some shortages may be mitigated in the long run through pipeline development. TEF has experience recruiting diverse candidates for education programs that lead to mid-level, technical, and professional patient care jobs. Leveraging existing TEF for resources such as tuition and instruction can assist candidate in selecting programs for which there are current and future shortages.

Furthermore, DSRIP and other ACA related changes in the health care system are driving wide-scale transformation of the system and increasing demand for certain job classifications, such as care managers, specialists, nutritionists, PAs, and NPs. With the overlap of multiple PPSs within our service area, we also anticipate a significant increase in hiring competition by competing systems. This will create challenges for any New York City PPS to ramp up DSRIP projects quickly. Proper vetting of newly hired staff for fit to role will also be critical to ensure patients are supported by practitioners and a system that can meet their complex needs.

***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	20%
Retrain	20%
New Hire	25%

Section 5.2 – WORKPLACE RESTRUCTURING - RETRAINING EXISTING STAFF :

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

Description:

Please outline the expected retraining to the workforce.

***Retraining 1:**

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

As patient populations are identified and patient services are defined, there will be a critical demand for qualified, culturally competent staff. Additional analyses of the current system of care versus the future state of operations, job design, and worker assessments will determine the knowledge, skills, and competencies employees will need to deliver appropriate services to the targeted populations and communities. Current staff will be expected to be competent in delivering patient population specific care. When a need for additional, different, or enhanced competencies or skills sets is identified, the PPS will determine whether the employee(s) or category of employees are positioned for training, retraining, or redeployment.

Much of the initial training will be job-specific and aligned with the scope of services being rendered. Although retraining will be voluntary, it will be a key element in maintaining and expanding upon our workforce to meet DSRIP metrics and milestones. As such, we will do our utmost to impart the value of retraining opportunities to our current workforce through multiple training opportunities. If employees refuse training, they may be transitioned into other comparable roles, if available.

In order to meet the needs of certain populations, the demand for qualified, bilingual workers may limit candidate pools and opportunities for redeployment of staff. MSPPS will work with labor representatives to manage the impact on the current workforce. Market demands will

also impact the need for higher wages if personnel shortages are identified and/or positions requiring a higher level of competency/licensure are required. New rates and benefits will be negotiated with labor if deemed necessary or market driven.

Overall, our retraining strategy will focus on improving quality care outcomes and healthcare worker engagement. We believe it is critical to develop mechanisms for recruitment, while dispersing new skills and skill enhancement throughout the workforce.

We will align training to meet new hiring needs. For example, the following occupations would receive training as detailed below:

Care Managers: Training will equip care managers with the knowledge and skills to work with complex populations, with detailed information on various chronic conditions, co-morbidities, and treatments, as well as best practices for working within a multidisciplinary team.

Patient Navigators: Training will focus on securing a shared understanding of chronic diseases, social determinants of health, cultural competencies, available patient and community resources, and how to effectively navigate third party systems. Communication skills, customer service, and strategies to increase patient satisfaction will be included. Training will be highly interactive utilizing peer exchanges and group work to reflect real time situations.
Community Health Workers (CHWs): CHW training programs such as CMMI project training modules, CUNY's credit bearing CHW certificate, and CHW Network's training program will serve as a baseline for CHW training. By using standardized approaches on appropriate terminology, customer service strategies (particularly in challenging situations), personal safety, behavior change theory, and ethical and cultural consideration when working with patients with various needs, MSPPS will ensure alignment with other PPSs in the service area. This training approach will also strengthen our overall cultural competency.

***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.

In the event that overall workforce needs change due to dramatic delivery system transformations, impacted staff will be retrained if deemed competent to work in new areas. MSPPS will work with labor representatives to coordinate retraining and identify specific job opportunities to maximize the use of available candidate pools. The utilization of candidate pools comprised of displaced employees will be the primary referral source to meet workforce demands provided that they are qualified to perform new job functions. It is expected that retraining of employees will have a minimal impact on current wages and benefits.

***Retraining 3:**

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

The PPS will support employers and workers to ensure maximum redeployment of staff. This effort will be supported through the engagement of TEF and our labor partners. For employees where their current jobs are no longer available at certain locations, the MSPPS will engage those employees early on to provide a number redeployment options or to identify to the extent possible alternative options to redeployment, such as retraining. For those who do not undergo redeployment, actions will adhere to existing collective bargaining agreements. If there is no collective bargaining agreement, the employer will engage the employee and to the extent possible propose alternatives. MSPPS will support partners in working towards solutions should displaced employees refuse redeployment.

***Retraining 4:**

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

We have directly engaged 1199SEIU, NYSNA and TEF representatives in developing our retraining plan. As implementation moves forward, we will continue to collaborate with labor unions and their affiliated training entities to refocus training efforts and resources and ensure they are in sync with clinical and market demands. Union and management will work in alignment along three distinct tracks: 1) redeployment and relocation of job functions of qualified staff, 2) retraining of staff via internal or external training programs, and 3) negotiation of workforce changes in the event current staff refuse retraining. Labor-Management relationships will be critical in effectively managing human resources. Planning of new services must include effective communication with union leadership to minimize employee disruption and ensure that training efforts are pre-planned and built into long term strategic goals. In preparation for systems change, the TEF Labor Management Program will support process redesign and worker/community engagement in system reform, making new clinical protocols and new delivery system designs transparent to healthcare workers early in the implementation stages.

Mount Sinai Hospitals Group (PPS ID:34)

***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	40%
Partial Placement	20%

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.

In coordination with 1199SEIU, NYSERS, NYSNA, 32 BJ and other labor organizations in the health sector, the PPS will build on existing placement assistance programs to create a redeployment program that includes early assessment and identification of workers impacted, identifies redeployment or new employment opportunities, and supports staff through transitions. Through this program, management will consider, but is not limited to, the following factors when determining the suitability of other positions for displaced staff:
-Pay/job classification
-Employee personal preferences, qualifications, and career goals
-Working environment
-Hours of work
-Type of work, including the minimum skills necessary

MSPPS will work with partners to find appropriate job alternatives for redeployed staff with comparable terms and conditions. The TEF Employment Center (the Center) will support this effort by helping to identify, recruit and screen candidates for new jobs in the existing system in which partners currently list job openings. The Center also advertises and recruits candidates from various schools and sources, and conducts initial pre-screening. The Center and the TEF Job Security Fund can also provide assistance to impacted workers, including skill and aptitude assessment, retraining, and interview and resume preparation.

Essentially, the Center is currently a clearinghouse for job placement and could be expanded beyond its current role. A computerized clearinghouse of new jobs by location, wage and benefits, and job skills is needed across all PPSs. Such a clearinghouse will allow staff to search a database and explore opportunities by reviewing the set of skills that an employee currently possesses in her/his position, as compared to the required skills of newly available positions.

As the delivery system transforms and the need for different types of skills are more clearly defined, there will be a shift in how services are provided to the patients served by the PPS at institutions, such as hospitals, community health centers, primary care sites, and long-term care facilities. These shifts will undoubted impact workers in those settings. The growth in community-based services, coupled with the corresponding decrease in the utilization of the inpatient services, will reshape some of the traditional roles of healthcare provider agencies. There will be an increased need for individuals qualified to assess and treat patients in the community; and staff, such as care coordinators, who will assist clients to navigate the system to find services that meet their specific needs.

DSRIP's goal to reduce avoidable hospitalizations statewide will result in fewer hospital beds and create staff redundancies among support staff at the inpatient level. This will mean that middle-skill positions, which do not require a four-year degree or licensing, may be reduced. However, this may be offset be additional demand for services as more New Yorkers gain coverage through the ACA.

Internally within organizations, the redeployment process will identify and redeploy staff within the same institution to fill internal vacancies for which they are qualified. External opportunities could also be identified if needed. The implementation of DSRIP projects will create a need for supportive services provided in the community by similarly middle-skilled staff working as peer navigators, community outreach workers and health promotion workers and home health aides. In addition, with some retraining, displaced workers could upskill to become medical coders, support staff within call centers or the MSO, or provide other technical support.

Mount Sinai Hospitals Group (PPS ID:34)

***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.

As PPS partners identify roles and tasks that may no longer be required in a particular setting, they will communicate first to the employees and their labor representatives, then notify the PPS through the Center. MSPPS will work with partners to conduct early analysis and identification of workers impacted. Job training will be provided to increase skills where needed, and to cross-train employees to broaden their abilities to meet the requirements of new positions. Such retraining is currently available through TEF, as well as through partnerships with managed care plans. Cross-training and broadening of home and community-based services staff will be considered to reduce coverage costs and increase operational flexibility.

The resources of partner organizations and market forces will, in part, determine the impact of redeployment on employee wages and benefits. The PPS will collaborate with labor groups early to evaluate any potential impacts related to employee seniority, wages, and benefits. To the extent possible, it is our goal to minimize impacts to workers and identify early indicators to ensure adequate supports are available to impacted workers.

***Redeployment 3:**

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

Some redeployment may be necessary, and others voluntary, depending on a number of factors. Per our redeployment process, labor unions and employers will help employees identify positions similar to their current assignment and support them in transitioning to new jobs. Where workforce reductions may be necessary, or if redeployment is refused by an employee, the PPS will work in coordination with organized labor to identify employees who may be amenable to an early retirement package. Support of formal educational efforts undertaken by individual employees could include temporary accommodations by employers, such as a reduction in hours worked or changes in shifts that are approved in anticipation of that staff person achieving a skill or certification useful to the new position.

***Redeployment 4:**

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

We have directly engaged labor representatives from 1199SEIU, NYSNA, and TEF to develop and support our retraining plan. These partners will assist in career and vocational coaching to further assist in the transition, which can help provide a better understanding of new positions so that employees can assess the best fit. They will also provide access to educational resources, training funds, and the aforementioned proposed clearinghouse.

The role of labor representatives and training funds in this process will be vital to the success and continuity of care as retraining and redeployment occurs and care settings shift. Their role will include:
-Educating employees about changes to the delivery system;
-Supporting and counseling employees about their future options;
-Collaborating with PPS partners to determine community needs and inform how the workforce can be developed and enhanced to meet these needs;
-Strategizing with the PPS and partners on how to be most effective in the redeployment process;
-Supporting the PPS in identifying opportunities for redeployment, retraining, and assistance in placement; and
-Providing ongoing training and education to help employees upskill

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.

The successful implementation of DSRIP, with its emphasis on prevention and primary care, reduction in avoidable hospitalizations, and

Mount Sinai Hospitals Group (PPS ID:34)

improved outcomes, will most likely require the addition of a variety of new job categories. These include, but are not limited to:

Direct Patient Services:
PCPs, NPs, PAs and Certified Nurse Midwives - These clinicians will provide comprehensive, high quality clinical services with a focus on prevention, patient engagement, and cultural sensitivity.

RNs, LPNs – These positions will support the clinicians in the treatment, monitoring, and education of patients.

Medical Assistants – These positions will provide support to the clinical staff (vital signs, medical histories, updating medication lists, providing translation services, etc.).

Physical/Occupational Therapists - This staff will provide rehabilitation services in long-term care, primary care sites, and in patients' homes.

Case Management and Clinical Support Services
Case Managers - As part of clinical care teams, these employees will work closely with patients to ensure that care plans meet their needs and are implemented. Case managers provide support to both the clinicians and patients to ensure that the desired outcomes are understood and achieved.

Patient Navigators - These employees will be responsible for working with patients to comply with assigned care plans. They will provide support services that include, but are not limited to, accompanying patients to clinical appointments; connecting patients to needed social services, benefits, and supports; assisting with communication between patients and clinicians; and collaborating with care teams on medication adherence.

Home Attendants – These employees will provide support services to patients who require assistance in the home.

Community Outreach Workers – These workers will assist in the identification and engagement of patients who have been lost to follow-up or have not responded to the clinical teams.
Patient Advocates - In collaboration with the clinical team, these advocates work with patients to resolve situations that prevent them from complying with care plans.

Behavioral Health Services:
Psychiatrists/Psychiatric Nurse Practicioners - These clinicians will provide treatment services as well as supervision and support to the clinical and behavioral service support staff.

Psychologists – These providers will focus on behavioral health treatment, screening, and prevention services, as well as the supervision of behavioral services support staff.

Social Workers – These providers will work with clinicians and patients to ensure understanding of and compliance with treatment plans, medication adherence, and connection to social services and benefits.

CASACs (Certified Alcohol and Substance Abuse Counselors) - These providers will provide screening, prevention, and some substance abuse treatment services.

Peer Support Workers - As members of the clinical team and under the direction of the clinical staff, these workers will provide direct outreach and support to patients, with particular emphasis on achieving patient engagement and participation in the achievement of care plan goals.

IT Infrastructure and Data Collection/Reporting:
Information Technicians – These employees will work on the development, management, and support of the IT infrastructure required for the implementation of DSRIP projects.

Mount Sinai Hospitals Group (PPS ID:34)

Clinical Informatics - These workers will be instrumental in developing the design of the tools and workflows for data collection, validation, and reporting of outcome indicators required from all PPS partners.

The MSPPS intends to invest $10 million in DSRIP funds to workforce needs, however this estimate may change depending on final attribution, the maximum project value, and the PPS achievement of DSRIP metrics and milestones.

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	200
Physician	500
Mental Health Providers Case Managers	600
Social Workers	500
IT Staff	70
Nurse Practitioners	1,000
Other	2,350

Section 5.5 - Workforce Strategy Budget:

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

Funding Type	DY1 Spend($)	DY2 Spend($)	DY3 Spend($)	DY4 Spend($)	DY5 Spend($)	Total Spend($)
Retraining	350,000	1,225,000	1,225,000	525,000	175,000	3,500,000
Redeployment	100,000	700,000	700,000	300,000	200,000	2,000,000
Recruiting	175,000	350,000	1,225,000	875,000	875,000	3,500,000
Other	150,000	200,000	250,000	200,000	200,000	1,000,000

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.

Across the MSPPS partnership, we currently collaborate with a number of state and federal agencies on worker retraining programs, including the AIDS Institute, CPI, CTAC, OMH Training (including CTAC), NYS DOH, HWRI, OASAS (including SBIRT Certification), SAMHSA Technical Assistance, Office of Children and Family Services, UAS Training Program, and HRA. The Icahn School of Medicine at Mount Sinai provides world-renowned training for physicians and has received numerous awards for its innovative training programs, for example the Health Care Innovation Awards for integrating geriatric care within emergency department care.

In parallel with DSRIP project implementation planning that will begin early next year, the MSPPS Workforce Committee will engage in workforce planning that includes identifying all existing state programs that may be leveraged to support our efforts in recruitment, retention, and retraining of existing staff. We will work with the Icahn School of Medicine to retrain physicians for new roles in care teams, as well as integrating population health management training into our current curriculum. This training may leverage a number of state programs, including Physician Practice Support, Ambulatory Care Training, and Primary Care Service Corp. Furthermore, we will work closely with our training partners to build upon other existing training resources and collaboratives to support our training needs. We will also, in collaboration with TEF, identify additional opportunities to work with other PPSs to develop joint training opportunities around alignment of our vision for the workforce.

The MSPPS intends to leverage existing workforce programs to the extent possible, as well as invest $10 million in DSRIP funds to workforce needs, however this estimate may change depending on final attribution, the maximum project value, and the PPS achievement

Mount Sinai Hospitals Group (PPS ID:34)

of DSRIP metrics and milestones.

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.

The Workforce Committee is comprised of key union and workforce stakeholders and HR experts nominated by PPS partners and identified by labor to ensure adequate workforce representation in the PPS. Committee members attended regular meetings open to the public and promoted through our newsletter and website.

Workforce stakeholders were engaged in the development of our workforce strategy through the committee and through two surveys deployed to partners to solicit their feedback pertaining to workforce. The first survey was distributed to providers in October to assess the current workforce landscape. Our goal was to gain a better understanding of how the workforce currently looks within the service area and identify gaps. The second workforce survey was released in November to identify partners' future workforce needs based on their participation in DSRIP projects. The committee incorporated survey data applied this information as they developed the comprehensive workforce strategy.

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

MSPPS has engaged and worked with labor groups who represent current and future employees of the PPS, but worked most closely with 1199SEIU and NYSNA. We are in the process of working with representatives of labor groups to schedule opportunities for MSPPS representatives to meet with and answer questions of front line workers. We plan to work within the already established union communication structure to ensure that there is clear and understandable communication between front line workers and management.

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

The MSPPS has reached out and engaged frontline workers in a number of different ways. We have invited frontline workers and union representatives to all public Town Halls and community board meetings. All interested parties, including frontline workers, are added to our PPS newsletter listserv, which contains weekly PPS and DSRIP updates , upcoming meetings, and opportunities for participation. In addition, we invited all listserv members to borough workgroup events in Brooklyn and Queens. Town Halls, community board meetings, and borough workgroup events provide an opportunity for frontline workers to shape how their community and jobs will be impacted by DSRIP and the development of an integrated health care delivery system. The PPS will continue to work with our partners to coordinate efforts to engage frontline workers in DSRIP implementation planning through partner communication channels.

***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.

We currently have an established PPS stakeholder engagement process that the PPS will continue to develop and expand. Our twice monthly public Town Hall meetings are held in person and by webinar, allowing stakeholders to engage with the PPS in the way that is most convenient for them. Our weekly newsletter provides timely updates on progress of the PPS and contains information about upcoming events for stakeholders. All meetings are public and posted on the PPS website. Materials and presentations from committee meetings and Town Halls are posted to the website, and video and audio of the meetings and webinars are posted as well. Moving forward, we will develop a suite of workforce engagement materials tailored to different sectors of the health care workforce to support education on DSRIP delivery system transformation. PPS leadership will also continue to engage in high-level conversations with labor to identify and address structural barriers to DSRIP implementation.

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

DSRIP PPS Organizational Application

Mount Sinai Hospitals Group (PPS ID:34)

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.

Mount Sinai Hospitals Group (PPS ID:34)

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 MSPPS will facilitate real-time access to patient information at the appropriate level of detail per provider and service type, while ensuring patient privacy and data security in compliance with all state and federal laws and policies. Providers must agree to comply with PPS policies regarding access and use of private health information (PHI). The IT Committee will be responsible for implementing processes to monitor data sharing and audit confidentiality practices throughout the PPS in accordance with standards defined by PPS leadership. The PPS will leverage the current processes within Mount Sinai, such as Healthix Portal, as well as solutions defined by the state and SHIN-NY, to inform a uniform consent management process and provider user-based access controls. All data sharing protocols will be standardized via data use agreements executed between the PPS and our partners. IT Committee will be responsible for implementing a data governance model approved by PPS leadership.

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

The MSPPS will develop specific provider-level user profiles, roles, and confidentiality definitions to inform data use protocols. The IT Committee will leverage current policies and procedures related to access and management of PHI, electronic data security measure, and mitigation measures in the event of perceived risks or potential breach. User profiles will be aligned with the PPS consent model, ensuring appropriate "break the glass" provisions are in place. Partners will be required to formally confirm their acknowledgement of these policies and their ability to comply. Each partner will be required to complete an annual survey and undergo regular security/user access audits to ensure compliance with PPS standards. Partners will be required to identify an IT lead within their organization who is knowledgeable regarding HIPAA privacy provisions and demonstrate competency through annual training opportunities developed by the IT Committee.

***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.

Mount Sinai Hospitals Group (PPS ID:34)

The IT Committee completed a preliminary assessment of partner IT platforms and capabilities using the national readiness standards developed by HIMSS. This will be supplemented by a detailed DSRIP-focused assessment. Recognizing the diversity of providers, breadth of platforms, and varying degree of IT maturity, the IT Committee will deploy a multi-tiered solution to ensure real-time data exchange and access across the PPS for mature IT organizations, and increasingly real-time access for less IT mature organizations. As DSRIP advances, less IT mature partners are expected to demonstrate movement towards HIE readiness. At the most basic level, paper-based providers will likely submit and access data via a basic web-based portal, supported by central call center. More IT-mature organizations will share/access data through a common integrator supported by MSPPS, in coordination with regional and statewide supported solutions (RHIOs/SHIN-NY).

Through coordination with RHIOs and statewide solutions to address intra- and inter-PPS data exchange and access, the MSPPS will create a complimentary data repository into which providers will push and pull data. The HIE data repository will establish appropriate data feeds based on the providers level of IT maturity, enabling real-time data exchange. More mature organizations will maintain continuous data streams, while others will likely batch data uploads and access the repository through a secure web-based portal.

IT Committee will establish specific IT minimum standards and capabilities by the type of provider and for each project to inform incremental IT adoption requirements. The IT Committee will develop a change management strategy with the Clinical Committee to inform appropriate workflow, data access, and systems development and upgrades. Lastly, the IT Committee will proactively identify late adopters (i.e., those at-risk for performance) to identify remediation strategies with PPS leadership.

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 MSPPS will establish a Performance Management Workgroup (PMW) responsible for collection, monitoring, and dissemination of key performance (quality, utilization, satisfaction, and financial) and outcomes data. Given the need to include competencies across our committees, this workgroup will be comprised of members from the Clinical Committee, IT Committee, Data Governance subgroup, and Project Management Office.

The PMW will leverage the experience within Mount Sinai, in which performance groups currently monitor over 500 metrics across five domains: Finance, Operations, Quality, Research, and Safety. The PMW will be responsible for performance management for the PPS as a whole, by organization, provider, and target populations. The PMW will report to the Leadership Committee and coordinate with other committees (e.g. Finance and Clinical) to monitor, refine, and bring to the attention of leadership opportunities for improvement in DSRIP and population performance, as well as proactively identify areas of risk and/or underperforming providers. Performance dashboards and control charts will be maintained to continuously monitor shortfalls and inform rapid cycle improvements.

***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.

Data provided via the PMW will drive our effectiveness in achieving the Triple Aim. The PMW will define key indicators and metrics across population health domains, expanding on those utilized within ACOs, to include productivity, utilization, cost, referral management, and

Mount Sinai Hospitals Group (PPS ID:34)

care management process indicators such as satisfaction, appropriateness, and timeliness of care. The dashboards will enable transparent performance monitoring that will inform business, operational, and clinical decisions as part of ongoing rapid cycle evaluation. Dashboards will be visible at the provider level (peer groups), with select indicators reported to appropriate committees and leadership. The PMW will be charged with implementing Rapid Performance Improvement Workshops, leveraging the Mount Sinai Lean/Six Sigma competencies and MSO to drive continuous improvement initiatives. Annually, the PMW will develop additional core population health, DSRIP, and provider specific metrics for performance management.

***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 PMW dashboards will be informed by commercial solutions currently used for performance management, providing benchmarks and peer ranking. These dashboards focus on key population health capabilities (e.g. Meaningful Use, PCMH adoption), and measures from existing quality improvement data sources (i.e. HEDIS, NQF, and NCQA), and will include specific DSRIP metrics and milestones to gauge provider performance and progress towards bridging clinical outcome gaps. Through provider performance evaluation and continuous quality improvement activities, the PMW will provide technical assistance to providers and recommendations to Leadership Committee that will inform development of common clinical standards, workflows, budgeting, and performance-based reimbursements to drive further improvements. These activities will support PPS learning collaboratives, foster innovation, and enable the governing body to make data-driven decisions around resource allocation and provider engagement.

***RCE 4:**

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

As the PPS transitions from fee-for-service to value-based payments with greater transparency around quality, patient satisfaction, cost, and performance, the MSPPS will work to advance provider competencies in population health and managed care using real-time data. The PMW will make recommendations for DSRIP implementation course corrections and provider remediation strategies. As the network advances and increases the accuracy/consistency data management, the RCE process will improve, providing more meaningful data to DOH/CMS and payors, while providing more patient and provider-specific data points to inform PPS-level decision making, downstream provider workflows, and clinical guidelines. Performance standards will increase incrementally over time, continually raising the collective PPS expectations and minimum standards. This will ensure that the majority of providers are progressing in alignment with our vision for population health and clinically integrated care delivery.

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

DSRIP PPS Organizational Application

Mount Sinai Hospitals Group (PPS ID:34)

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.

NYC is home to a myriad of different ethnic, religious, and social groups, many of whom have varying views on beliefs around health, wellness, and the overall delivery of care. The communities served by the MSPPS reflect this diversity. NYC has a greater proportion of African Americans, Asians, Hispanics, and multi-racial residents than the state as whole. More than a third (37%) of NYC residents are foreign-born and nearly half speak a language other than English.

Data from our CNA provider survey show that there are significant barriers to accessing primary, specialty, behavioral health, substance abuse and other basic care needs for Medicaid patients, in part due to cultural competency challenges. PPS providers noted that poverty, language barriers, stigma around substance abuse and mental health disorders, and cultural beliefs were key barriers to accessing care. In addition, many MSPPS providers serve populations who face discrimination and social stigma, for example patients involved with the criminal justice system, individuals with HIV/AIDS, the LGBT community, those from orthodox religious sects, individuals with mental illness, and the developmentally disabled.

Providers are challenged in communicating effectively with the patient population and understanding how different backgrounds and cultural beliefs and norms influence patient-provider interactions, patient decisions, compliance with care plans, and achievement of health goals. To ensure success, MSPPS must provide tailored services through culturally competent practices that: 1) address poverty and social stigma, 2) are culturally and linguistically appropriate, and 3) promote the overall goal of the PPS to achieve the Triple Aim.

Mount Sinai Hospitals Group (PPS ID:34)

Through collaboration with partners we will conduct outreach, engagement, and wellness activities for populations with disparities to address these challenges and ensure success, leveraging the expertise of the Mount Sinai Health System and PPS partners.

***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.

MSPPS is committed to developing a culturally competent organization by developing and implementing several strategies, including workforce training and education. Specific objectives and strategies include:
- Fostering an understanding and application of cultural competency, across levels, practices, and roles
- Providing foundational instruction on culture and stigma and how it impacts health and service delivery to our care navigators, as well as other professionals within our service area
- Tailoring training for specific frontline and other patient-interacting jobs, using various techniques to illustrate application of concepts and information
- Engaging a variety of PPS stakeholders to select training vendors, validate content, and provide and/or evaluate instruction
- Embracing best practices to facilitate content standardization across PPS partners, optimize access to instruction, and enable staff to refresh knowledge and skills on demand
- Incorporating cultural competency into other workforce development
- Incorporating Culturally and Linguistically Appropriate Services (CLAS) Standards in to the daily work of all employees
- Providing resources to address cultural competency questions and issues as they arise from stakeholders and sharing learnings across the PPS to inform training of frontline workers
- Matching employees to patients based on linguistic and cultural needs
- Identifying opportunities to increase the employment of individuals from communities and cultures the PPS serves will enhance the patient experience (e.g. bilingual frontline staff)
- Implementing programs and practices that support the entry of culturally-diverse staff into targeted health care occupations (e.g., tuition reimbursement)
- Maintaining an inventory of staff language abilities to enhance service delivery
- Providing instruction in medical terminology and medical translation to strengthen the competencies of staff whose jobs require multi-lingual skills

***Competency 3:**

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

There are a wide variety of CBOs currently within the PPS, from organizations serving the criminal justice reentry population system to senior social services agencies. These organizations are deeply connected to the communities they serve and their participation is critical in instilling cultural competency across the PPS.

We will look to our CBO partners for best practices in cultural competency training and service provision, building from their successes as we implement trainings and information sharing sessions for all PPS partners. The PPS will collaborate with key CBO partners to gain a more comprehensive understanding of how project development and implementation will impact and benefit the specific target populations that make up our PPS.

Our goal is to expand CBO services throughout the course of DSRIP and we anticipate that their role will grow and evolve. Our DSRIP funds flow allocates 5% of funds to non-safety net providers, including CBOs that are non-Medicaid providers. Initially it is likely that CBO services will be partially funded through grants and PPS contracts to build upon current sources of CBO revenue. We anticipate an incremental expansion of CBO services within managed care contracts. Ultimately, integrating CBOs into core care pathways will demonstrate their value to medical providers and managed care organizations.

Section 7.2 – Approach to Improving Health Literacy:

Description:

Mount Sinai Hospitals Group (PPS ID:34)

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

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

***Literacy:**

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

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

Developing the health literacy of the population is integral to our overarching mission to improve health care delivery and outcomes for our most vulnerable populations. If the PPS were to approach DSRIP implementation assuming a baseline level of health literacy for the patient population we would be doing a disservice to our providers as well as our patients. The vast majority of adults have trouble understanding health information that is available in our everyday lives. Communities of color and low-income individuals are more likely to have low health literacy, and because of this, gradually increasing health literacy throughout our patient population is a high priority.

To be successful in DSRIP project implementation and patient engagement, we must address low levels of health literacy within our service area by developing appropriate policies, procedures, and educational materials and ensure that patients have the appropriate tools, information, and support to navigate the health care system.

We envision a two-pronged approach to increase the health literacy of our patient population. First, we will recruit and train employees who will be able to work with various patient populations to raise health literacy levels. Second, we will produce standardized, multi-media materials tailored to fit the needs of specific communities. These materials will include printed pamphlets translated into multiple languages, as well as e-learning and audio/visual vignettes. We will also develop interactive sessions to meet the experiential learning needs of the population. At each step of the way, we will leverage the services of professionals with expertise in training and work to strengthen connections with community stakeholders and established organizations.

Many CBOs within the PPS are leaders in effectively serving and educating individuals in health literacy. These organizations are ambassadors for increasing the health literacy of our population. In conjunction with working collaboratively with CBOs in this endeavor, we will employ surveys and proven feedback models to periodically assess the current needs of the community and tailor our approach accordingly.

Not only will we leverage the expertise of CBOs in serving populations with low health literacy, we will also engage our training vendors in increasing cultural competency and health literacy within our workforce. We intend to work with 1199SEIU Training and Employment Fund (TEF), an organization with extensive experience incorporating cultural competency and health literacy into training programs. By incorporating TEF's worker training experience as an integral part of our future training workforce strategy, we believe achieving greater levels d health literacy among our patient population, as well as more culturally competent service provision, are goals that are well within reach for the PPS.

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

Mount Sinai Hospitals Group (PPS ID:34)

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.

Mount Sinai Hospitals Group (PPS ID:34)

SECTION 8 – DSRIP BUDGET & FLOW OF FUNDS:

Section 8.0 – Project Budget:

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

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

Scoring Process:

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

Section 8.1 – High Level Budget and Flow of Funds:

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

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

The Finance Committee funds flow distribution will support goals in four areas: 1) supporting centralized project management, MSO services, governance, and DSRIP performance/reporting management, 2) incentivizing providers to utilize investments to build capacity, capabilities, and infrastructure for financial risk-sharing/value-based payments, 3) ensuring fragile partners and inpatient providers sustain the transformation process while adapting to new business models and remain financially healthy in the long-term, and 4) providing direct financial incentives for providers to achieve DSRIP metrics and milestones.

The MSPPS proposed funds flow plan establishes five primary budget categories. Fund categories were weighted based on current understanding of DSRIP performance milestones, provider competency, and structural and process gaps that partner providers will have to achieve/bridge over the next five years. Leadership, with input from the Finance Committee, may also adapt the percentages of these initial funds categories following initial outcomes and lessons learned in the first performance year. The bulk of funds will be allocated toward provider performance incentives to ensure timely completion of milestones and metrics. Emphasis is placed on performance-based payments to incentivize achievement of milestones tied to scale and speed, rather than only offsetting provider expenditures, which may not directly correlate with achievement.

Providers will receive DSRIP funds based on a set of criteria, including number of lives impacted, role played in impacting patients and project performance, and complexity of each project. The methodology takes into consideration the level of resource commitment/effort by the partners and is designed to incentivize achievement of metrics and milestones. Five percent would be distributed to providers without attributed lives who provide valuable services (e.g., community-based organizations that are non-safety net providers) and/or otherwise not compensated through Medicaid. DSRIP funds will be budgeted by provider type and role or impact in projects, taking into consideration organization size, service area, lives impacted, and resource commitment and expenditures. Payments will incentivize coordination and positive impact on population health over time, rather than volume driven care.

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

DSRIP PPS Organizational Application

Mount Sinai Hospitals Group (PPS ID:34)

The PPS governance will closely manage allocation of funds, as outlined by the Finance Committee. Processes will be put into place by the Finance Committee, with Leadership approval, to ensure timely distribution of funds in accordance with the funds flow criteria and allocation model. Distribution of funds will follow successful demonstration of meeting the defined distribution "triggers" to be defined per funding category. Funding allocations, and subsequent changes, will be overseen by the Finance Committee, with Leadership Committee approval, to ensure transparent funds management in accordance with the PPS funds flow model and budget (to be finalized in Q1 2015), as well as input through the Finance and Leadership Committees on behalf of providers to ensure representative decision-making in the interests of the collective PPS.

Distribution of funds will be directly tied to goals set forth by PPS leadership based on Domain 1 metrics and milestones. Goals will be defined per project and provider type, based on role in projects and ability to impact scale and speed. The potential negative impact associated with DSRIP projects, primarily among acute care providers and specialists, will also be taken into consideration. Some funds may be allocated based on standard criteria, per provider type and role, to support such providers during DSRIP. As the cross-section of providers is represented through the governance structure, decisions related to evaluation of funds distribution will be representative.

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	25%
2	Revenue Loss	20%
3	Internal PPS Provider Bonus Payments	5%
4	Performance Based Payments	35%
5	Non-Safety Net and CBO funds	5%
6	Contingency Fund	10%
	Total Percentage:	100%

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

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

- Quarterly or more frequent reports on the distribution of DSRIP payments by provider and project and the basis for the

Mount Sinai Hospitals Group (PPS ID:34)

funding distribution to be determined by the Independent Assessor.

☑ Please click here to acknowledge the milestones information above.

Mount Sinai Hospitals Group (PPS ID:34)

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.

Providers were surveyed to gather information from partner organizations to assess performance, risk, capability, and network fit. As part of this process, key financial indicators, as well as audited and YTD financials were collected. Financial indicators collected from partners included days cash on hand, debt ratios, reliance on grants, payor mix, utilization by payor, recent or expected material changes to the organization, significant expected capital expenditures, and/or outstanding debt.

The Finance Committee developed a scoring process for evaluating provider financial strength and organized providers into peer groups based on provider type and assessed them with relation to the pre-identified key indicators. Partners within a peer group were measured on a bell curve. The bottom 25% were then identified for further and more detailed, organization specific assessment. Moving forward, the Finance Committee will continue to monitor these financial indicators, along with processes to engage partners proactively to assess potential risks before they impact provider performance, specifically with relation to DSRIP performance. As part of the budgeting and planning process in Q1 of 2015, the Finance Committee will complete a sensitivity analysis by provider type to assess DSRIP impact on potentially fragile providers in greater depth. Given the rapid inclusion of providers in the network in the final weeks of DSRIP Application preparation, this level of analysis was not practical. However, the project team did review comparable actuarial models by provider type in anticipation of addressing potentially fragile provider needs, which led the committee to provisioning both sustainability and contingency funds as part of funds flow. Following this analysis, potentially fragile provides and/or those most at risk to be impacted by DSRIP will be engaged by members of the Finance Committee to begin developing pro-active risk mitigation strategies.

Mount Sinai Hospitals Group (PPS ID:34)

***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.

The PPS expects several impacts as a result of DSRIP. Reducing existing volumes is anticipated to avoidable inpatient admissions and emergency room visits. Temporary impacts on cash flow as partners invest in DSRIP projects is also expected, based on either lag time in funds flow, timing for new services to increase volume, or need to make capital investments upfront. Finally, the PPS anticipates a shift to a greater proportion of value-based payments and capitation for providers and/or performance-based contracts.

With the overarching DSRIP objective of reducing 25% of avoidable inpatient and emergency room visits, there will be decreases in traditional hospital volumes. The extent of the impact will vary based upon how many of those avoidable visits providers currently have at their facilities and how readily providers can adapt to offset these losses through new services and roles and/or adaptation under the value-based payment models. In particular, already fragile organizations receiving supplemental state or grant funds will see a reduction in these funds as DSRIP becomes the single source of provider investment to bridge gaps. Progressive and diversified business models may lessen this impact. Larger, diversified organizations may have greater ability to reduce staffing levels as volumes change, but smaller providers may run into obstacles such as minimum required staffing that make it difficult to reduce direct costs as volumes fall. Additionally, providers offering one service among a significant number of competitors will be faced with the need to differentiate and demonstrate value above their peers, as contracting and performance-based contracts will focus on the development of narrow networks and quality providers.

The cost of implementing the DSRIP projects will also have a financial impact on providers. All projects require some investment by providers, whether it is in capital investments in the form of new buildings or IT systems, or an increase in operating expenses through adding new providers, staffing, contracted vendors, and non-capital IT upgrades, training, connectivity and implementation costs. The time delay inherent in the DSRIP program, with award dollars not coming for months after a performance period, will put pressure on available cash at providers. The availability of capital funding under the Capital Restructuring Financing Program could provide some relief to providers but it is likely those funds will require a significant match from the provider. Additionally, those providers who fail to meet DSRIP goals will lose out on some funding, while still having expended resources along the way and transformed business models, further extending potential financial gaps.

These impacts can be especially acute for those providers deemed financially fragile. The Finance Committee has begun to develop principles and criteria to access contingency and sustainability funds, recognizing the need to shore up providers as DSRIP activities negatively impact an organization's viability in the short-term, while balancing the need to incentivize providers to revamp business models for long-term success, focusing on investing in new opportunities and not upholding unsustainable systems.

Two particular areas have been identified beyond the reduction in avoidable and/or fee for service volume: IT systems upgrades and adoption, as well as investment in staff training and creation of new positions. As community-based providers and smaller organizations (e.g. adult day health care, long-term care, and social support services) seek to engage in DSRIP and population health, they will be required to make significant upfront investments to establish core systems and competencies to participate in care coordination, standardized disease management, targeted outreach initiatives, and further integration of care.

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.

The Finance Committee will develop a sustainability plan in the first quarter of 2015, outlining an incremental approach toward implementation of the DSRIP and the subsequent impact on provider operations, volume, and revenue. The plan will encompass both medical and non-medical providers and select CBOs, providing options and pathways for each class of provider during the transformation of the network through DSRIP and post-waiver. The plan will address key assumptions, risks, decision points, and considerations for provider types within the PPS. It must also take into consideration the attributed target DSRIP population, assessing medical management

Mount Sinai Hospitals Group (PPS ID:34)

models and utilization management activities that will be necessary to complement DSRIP activities and bridge the population health gaps. These services will be provided through a central MSO for the PPS, ensuring standardized, non-duplicated support that leverages economies of scale for the PPS.

As part of the sustainability planning process, the Finance Committee will assess the need for technical assistance for partners with relation to financial and operational restructuring based on the projected impact of DSRIP projects on organizations. In particular, potentially fragile organizations and/or smaller providers will be included in targeted educational forums to create a common understanding of potential DSRIP impacts, funds flow and available options, and resources to ensure financial success. Following this initial sustainability planning process, the Finance Committee will put into place "triggers" to flag potential risks for providers based on ongoing collection of key indicators and evaluation of provider financial well-being and DSRIP performance.

In order for the PPS to fulfill its role of promoting access to care for all Medicaid members, it must first ensure that it can sustain itself, which includes being able to obtain the funds necessary for operations. To this point, the sustainability plan will define specific financial and operational metrics that will allow it to track its success against the DSRIP project goals and that will allow for identification of potential performance issues within its provider network. Actual performance will be compared to budgeted performance at regular intervals and a process to address issues will be outlined.

***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 Finance Committee and PMO will implement a process to collect and review key financial indicators from partners on a regular basis throughout the year, reporting no less than quarterly to the Leadership Committee potential risks or issues that may impact the PPS or performance metrics. Ongoing submission of financial indicators will be a required activity of all PPS providers per the terms of the partner agreements, including ensuring safety net provider status is maintained as appropriate. Partners will also be assessed against historical performance, as well as peers and benchmark data, with acceptable thresholds set to flag risks as they arise in reports. As appropriate, the Finance Committee may engage with at-risk or fragile partners to help develop financial models and assess potential business models for potential sustainability opportunities. Should any risks be flagged, a subcommittee of the Finance Committee will be formed, representing appropriate provider types, to develop a financial remediation plan, request contingency/sustainability funds if appropriate, and engage in close monitoring of plan follow-through and achievement of defined short-term milestones.

***Path 3:**

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

One of the goals of MSPPS is to transition the PPS into an ACO-like organization, with partners capable of sustaining DSRIP outcomes and competing in a competitive value-based provider market within a narrow network. DSRIP provides the initial investment dollars and opportunity for PPS partners to learn to manage populations together, operate as a clinically integrated network, and build relationships and shared programs that support shared care coordination, data exchange, and competencies needed to succeed post-DSRIP. It is anticipated that well before year five, PPS providers will begin to engage in risk-sharing and/or value-based payment models as an extension of DSRIP activities for certain services with select providers ready for this next level of financial realignment. As DSRIP approaches the end of year five, the PPS will have already set into motion contractual agreements with managed care organizations (MCOs) focused on performance-based contracts and will have established the core population health infrastructure to sustain and expand DSRIP activities, as well as support a central MSO to provide comprehensive care for a defined population across the continuum of care.

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:**

Mount Sinai Hospitals Group (PPS ID:34)

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

DSRIP will result in improved efficiency and decreased per member cost of care for the Medicaid population, while improving quality outcomes and the patient experience. It represents a unique opportunity to invest in the population health capabilities of the PPS and its partners that will position providers for long-term sustainability through contractual relationships and value-based payments. Knowing DSRIP funding is limited both in terms of amount per year and the duration for which it is available, the PPS and its providers will have to rapidly engage with managed care organizations (MCOs) to understand the network provider expectations and opportunities for early collaboration around health care delivery for a defined population, based on the value-added services that will be developed through DSRIP.

MSPPS plans to engage MCOs in the region, to discuss current MSPPS project plans given their experience with the population, and to discuss how partnering on value-based reimbursement methodologies, bundled payments, and/or further delegated services around patient engagement and care management might further align the organizations. It is anticipated that these arrangements may start simpler and move towards more complex and shared risk arrangements like capitation as MSPPS develops its capabilities and financial ability to take on risk. This work will build upon Mount Sinai's current Health First shared risk experience and ACO experience, which will inform and support how Mount Sinai and the MSPPS will engage in value-based reimbursement methodologies.

***Strategy 2:**

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

Payment transformation creates a second source of potential income that will allow MSPPS to further invest in the integrated delivery system (IDS) that DSRIP is creating. A financially sustainable IDS is achieved by ensuring sufficient funds are allocated by provider type, providing additional resources for financially fragile safety net providers to ensure they can weather the transition, and ensuring that Medicaid population has access to the necessary services as defined by MCO partners and the state.

The move to value-based reimbursement methodologies across this large of a population, with its unique needs and requirements, is a big lift, both operationally and financially for PPS providers. The MSPPS has selected projects that have the ability to reduce preventable utilization by 25% and meet the DSRIP projects goals, but there are other projects and opportunities still to be mined, for which the DSRIP funding alone cannot cover the cost to implement. Through alignment with the state and MCOs, and the development of value-based reimbursement methodologies that allow all three organizations to share in the savings, there are further opportunities for improvements in cost and quality that will help provide financial resources to bridge IDS infrastructure needs. The Finance Committee will evaluate various financial incentive models and value-based arrangements that will be appropriate based on provider type and appetite for risk. This will provide a continuum of options for providers as they build population health competencies and operational foundation, as well as services, to successfully engage in DSRIP and other initiatives supporting the integrated delivery model.

Financially fragile safety net providers will have the opportunity over the DSRIP period to build up their competencies, resources, and experience base, as well as partnerships and increased referral base to succeed in a more competitive, value-based market. Such providers will have to selectively invest in services and capacity that will meaningfully impact patient outcomes, cost, and quality, ensuring they have a viable role within the PPS and long-term integrated delivery system.

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.

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

DSRIP PPS Organizational Application

Mount Sinai Hospitals Group (PPS ID:34)

☑ Please click here to acknowledge the milestones information above.

Mount Sinai Hospitals Group (PPS ID:34)

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.

Mount Sinai Health System (MSHS) is actively engaged in many population health activities, both independently and in partnership with other providers. The Institute for Advanced Medicine provides health navigation, care management, medical, and specialty care for people living with HIV. The nationally renowned Adolescent Health Center is first of its kind in providing primary, specialty, and mental health care and support to adolescents, regardless of ability to pay. The Visiting Doctors Program is the nation's largest academic home-based primary and palliative care program, providing medical and social work support to homebound, mostly frail and elderly adults throughout Manhattan. MSHS and many of our partners participate in the NYS Health Homes program, providing care management and clinical connections for the most high-need Medicaid beneficiaries.

We are committed to creating an integrated delivery system that will join programs and partners across sites and payors to effectively scale and tailor efforts to meet the needs of a large and diverse PPS community. Formal and informal partnerships with external health care providers, community-based organizations, and city and state agencies are key to broadening our reach. Strategic partnerships and provider collaborations have expanded our referral network, facilitated collaboration on innovative programs and best practices, and leveraged advocacy efforts.

MSPPS recognizes the critical importance of centralizing and expanding our population health infrastructure. The development of Mount Sinai Population Health Institute and MSO will integrate key functions and expertise that are vital for managing populations, while delivering exceptional clinical outcomes and efficiency. For value-based and risk-based contracted populations, those functions include payer contracting, population health analytics and operations, care management, wellness services, and population-based quality management and improvement.

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.

Given the size of our PPS and the breadth of our projects, it is likely that we will need to engage several workforce strategy vendors. Among these, we intend to engage the 1199SEIU League Training & Employment Funds (TEF) as our lead workforce strategy vendor for education, training, recruitment, and placement services for staff impacted by restructuring changes. These services will promote workforce development, engagement, and effectiveness critical to system-wide transformation. We look forward to working with other PPSs through TEF in a regional coordinator role, to the extent possible.

TEF, the largest labor-management training organization in the nation, is jointly governed by 1199SEIU and health care employers. It supports 250,000 workers and more than 600 employers across all health care sectors. Many clinical and non-clinical staff of our PPS partners have participated in TEF trainings and utilized TEF services.

With more than 45 years of experience in workforce planning, training, development, placement, and consultation, TEF has a strong track record of collaborating with New York State employers, unions, and training providers to design and deliver high quality programs in an

Mount Sinai Hospitals Group (PPS ID:34)

impressive breadth of subjects. For example, TEF has used NYS HWRI funding to offer training and education programs to over 76,000 workers since 2001, with a 97% completion rate. Current offerings range from occupational training for community-based workers to courses on chronic disease management, care management, and care coordination. We believe that TEF's track record speaks for itself. As a key training partner, we look forward to working collaboratively to minimize the disruptive impacts to our workforce. TEF's ability to effectively utilize funds from the public and private sectors, leveraging economy of scale, a vast network of vendors, and best practices gained through its national reach is an asset to our PPS.

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

DSRIP PPS Organizational Application

Mount Sinai Hospitals Group (PPS ID:34)

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 Mount Sinai Hospitals Group that all information provided on this Project Plan Applicant is true and accurate to the best of my knowledge.***

Primary Lead Provider Name: MOUNT SINAI HOSPITAL
Secondary Lead Provider Name:

Lead Representative:	Arthur Gianelli
Submission Date:	12/22/2014 05:20 PM

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