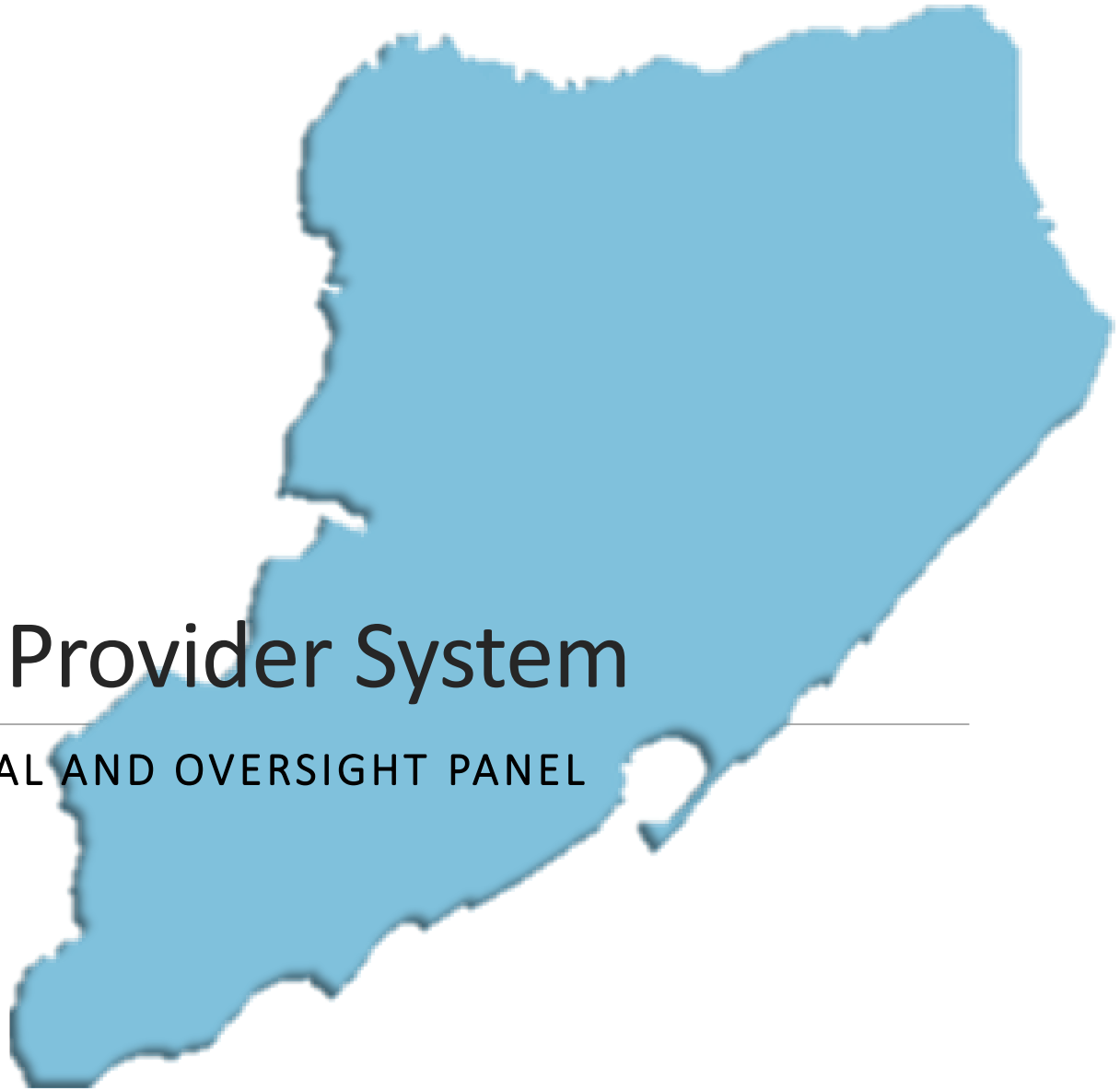
Staten Island
Performing Provider System, LLC



Staten Island Performing Provider System

PRESENTATION TO DSRIP PROJECT APPROVAL AND OVERSIGHT PANEL

JOSEPH CONTE

EXECUTIVE DIRECTOR

JANUARY 22, 2016

Staten Island Performing Provider System (SI PPS)

We are a limited liability corporation formed by Richmond University Medical Center and Staten Island University Hospital to implement Project Management Function.

- PMO staff recruited solely for program execution

Goal: Improve the quality and transform the healthcare delivery system of Staten Island

Breadth:

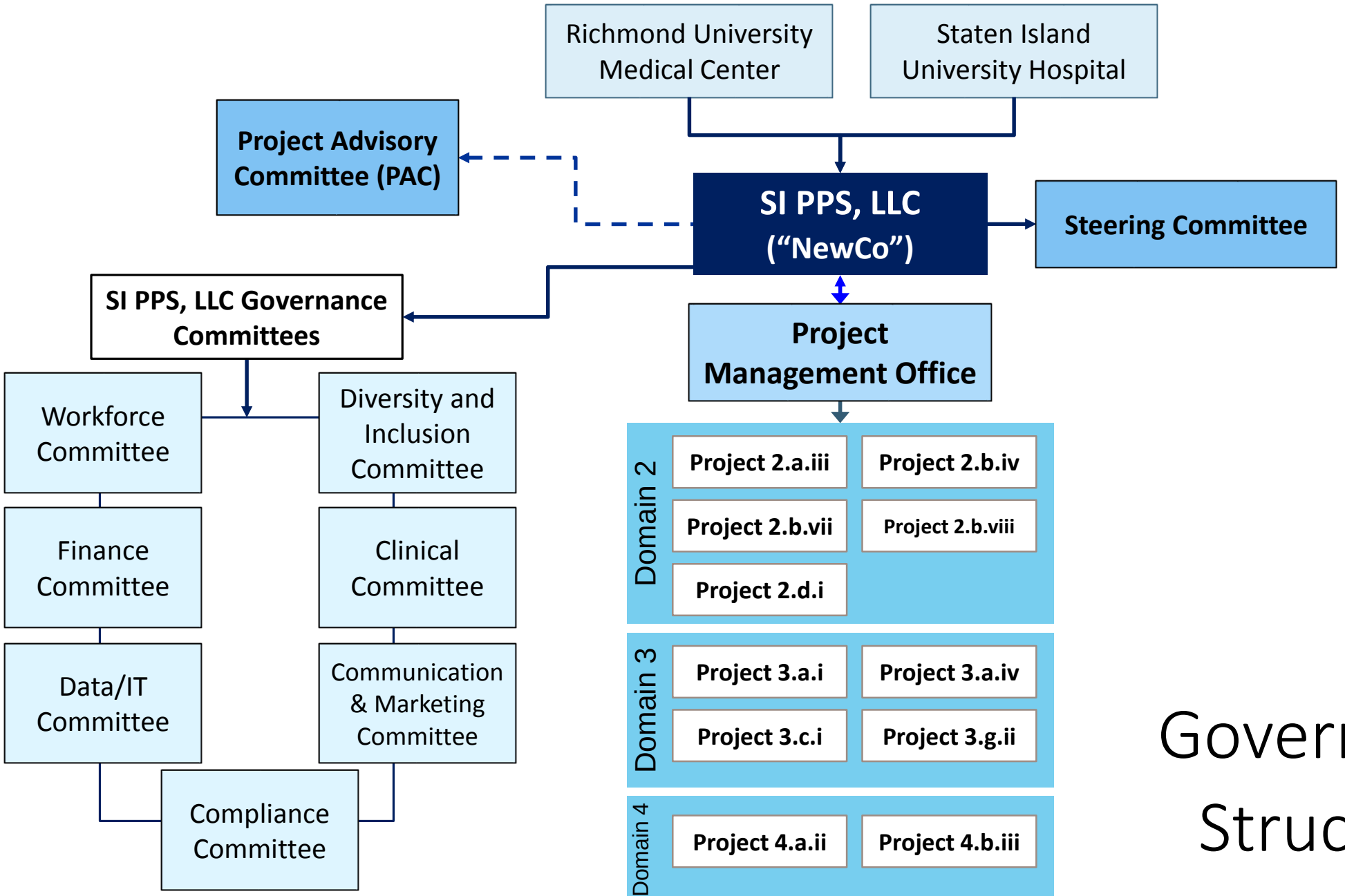
- 4 out of 10 Staten Island residents affected by DSRIP

Strategic Approaches to Innovation, Program Accomplishments and Updates

- Completed 100% PPS partner contract sign-offs with 56 signed MSA's
- Distributed over $10 million, 68% to non-hospital/CBO providers
- Supports Cross-PPS Collaboration
  - Regional Workforce PPS-wide Symposium
  - Lead for NYS PPS Cultural Competency (CC) and Health Literacy (HL) Collaborative
- Diverse CBO Integration: governance structure and projects, CCHL training and outreach
- Initiated innovative program to utilize Telemedicine in extended care setting
- Created Value Based Purchasing Population Health Improvement Program for community physicians
- Completed two rounds of INTERACT Training at nursing homes and Palliative Care assessment
- Leaders in workforce, training & benefits strategy; collaboration with unions, 1199TEF & community providers

11 PROJECTS

Behavioral Health	Long Term Care	Primary Care	Care Management	Home Care	Community Projects
Integration of Primary Care and Behavioral Health Services (3.a.i) 1250 4274 342%	Implementing the INTERACT project (2.b.vii) 69 311 451%	Integration of Primary Care and Behavioral Health Services (3.a.i) 1250 4274 342%	Health Home At-Risk (2.a.iii) 500 201 40%	Hospital-Home Care Collaboration (2.b.viii) 30 702 340%	Patient Activation Activities (2.d.i) 2500 6166 247%
Development of Withdrawal Management Services (3.a.iv) 100 124 124%	Integration of Palliative Care into Nursing Homes (3.g.ii) 105 285 271%	Evidence-based Strategies for Diabetes Management (3.c.i) 750 1653 220%	Care Transitions Intervention Model to Reduce 30 day Readmissions (2.b.iv) 120 505 421%		Strengthen Mental Health & Substance Abuse Infrastructure (4.a.iii)
Actively Engaged Q3 Target Actual Achievement Rate					Increase Access to High Quality Chronic Disease Preventive Care & Management (4.b.ii)



Governance Structure

5

Project Advisory Committee Membership

Steering Committee
Contracted CBO

Substance Abuse/Behavioral Health

Bridge Back to Life
Camelot of Staten Island
CHASI
Jewish Board of Family Services
Project Hospitality
Sky Light Center
Staten Island Behavioral Health
Staten Island Mental Health Society
CBC
YMCA Counseling Services
Silver Lake Support Services
South Beach Psychiatric Center
NAMI Staten Island

Faith based, Unions, LGU and MCO

NYC DOHMH
Healthfirst PHSP, Inc.
Empire BlueCross BlueShield, Healthplus
New York State Nurses Association (NYSNA)
1199 SEIU
UFT
Ocean Breeze Pharmacy
Nate's Pharmacy
Stapleton UAME Church
Borough Hall
FDNY/EMS

Nursing Homes

Carmel Richmond Healthcare and Rehab Center
Clove Lakes Health Care
Eger Lutheran Homes and Services
Golden Gate Rehab and Health Center
New Vanderbilt Rehab and Care Center
Richmond Center for Rehab and Healthcare
Seaview Hospital Rehab Center and Home
Verrazano Nursing Home
Silver Lake Specialized Care Center
Staten Island Care Center

FQHC

*Beacon Christian Community Center, Chair
Community Health Center of Richmond
Metro Health Clinic

Home Care Agencies

ArchCare Home Care
Visiting Nurse Association of Staten Island
Visiting Nurse Services of New York
Northwell Home Care

Hospitals

Richmond University Medical Center
Staten Island University Hospital

Physician Groups

University Physicians Group
Victory Internal Medicine

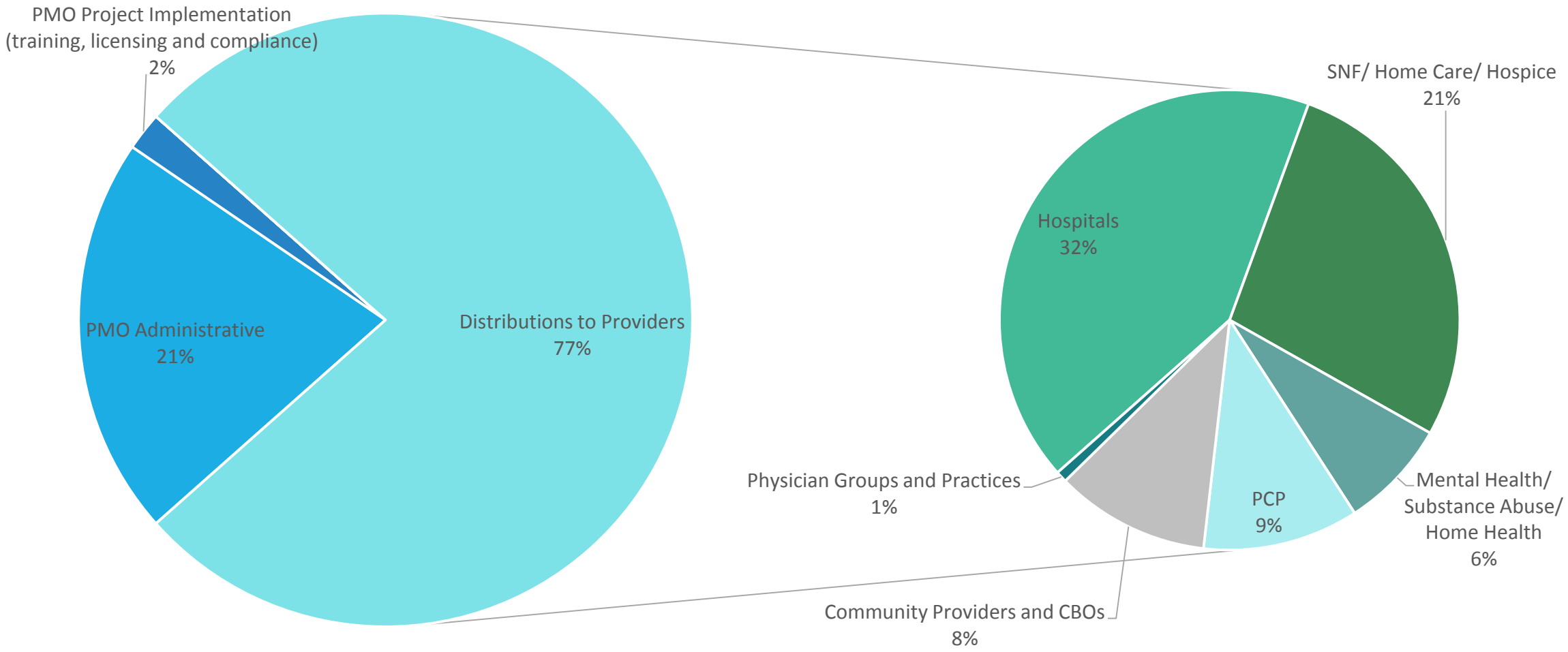
Community Alliances

A Very Special Place, Inc.
AABR, Inc.
Catholic Guardian Services
Eden II School for Autistic Children
Independent Living Association
Lifestyles for the Disabled, Inc.
Modest Community Services Association
Staten Island Aid for Retarded Children
GRACE Foundation of NY
United Cerebral Palsy of NY
HeartShare Human Services
Lifespire, Inc.

CBO Alliances

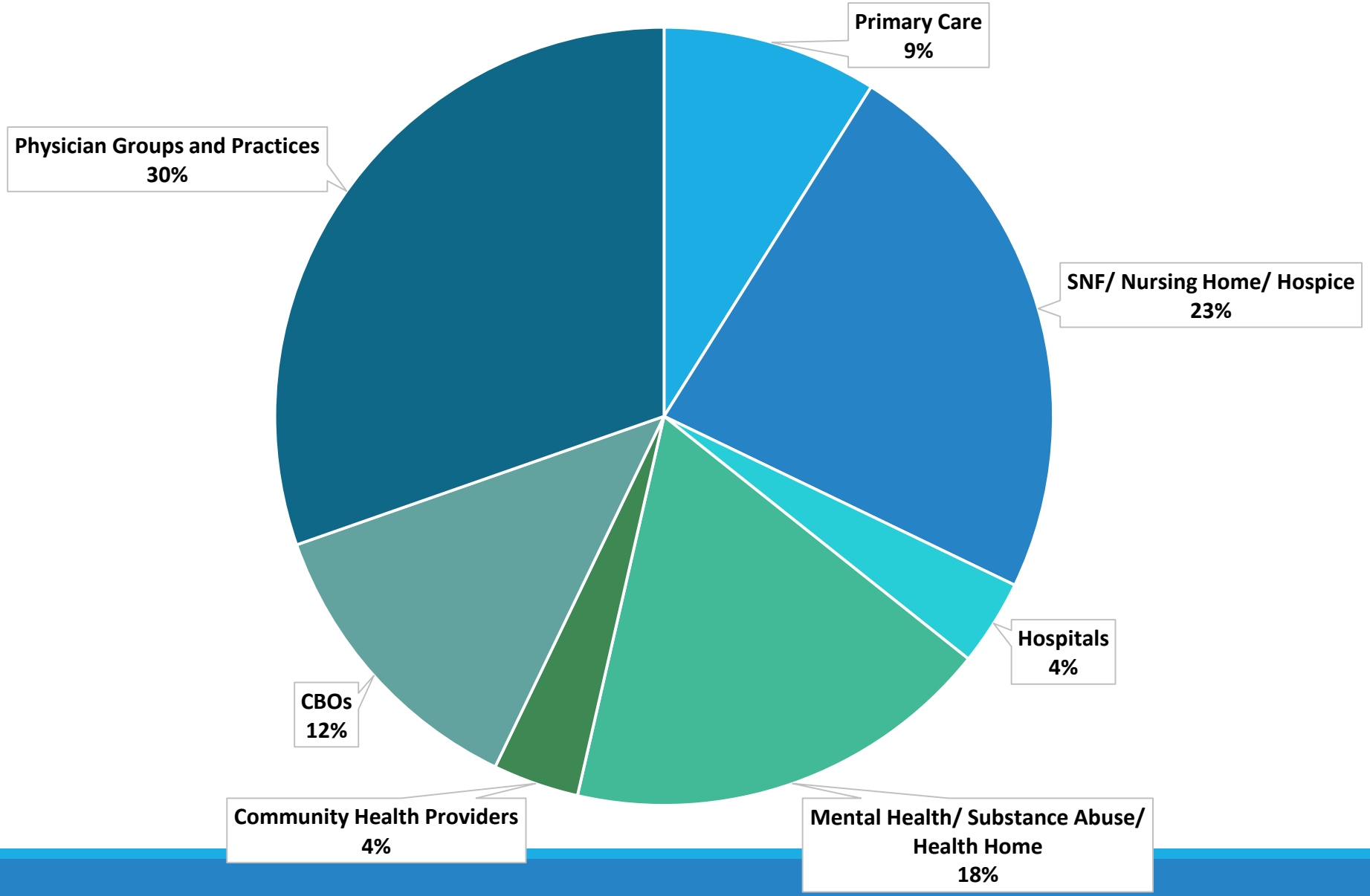
Person Centered Care Services
LGBT Pride Center of Staten Island
El Centro del Inmigrante
YMCA New American Welcome Center
Island Voice
JCC
Make the Road
Staten Island Partnership Community Wellness

SI PPS Current Expenditures: $10,093,704

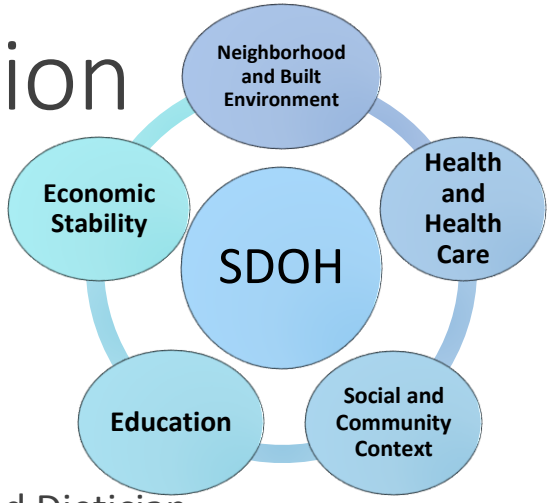


$10,241,895 scheduled to be distributed by Jan. 31, 2016

56 Master Service Agreements by Provider Type



CBO Strategy: Engagement and Collaboration



Training Partnerships with CBO's:

- Pride Center of Staten Island- LGBT Healthcare Equality
- Patient Centered Care Services- Sensitivity Training for Persons with Disabilities
- LEARN Committee/NYPL- Health Literacy

Diversity and Inclusion for all Staten Islanders

✓ Improved Language Access services for large immigrant population

✓ Health Literacy and Health Communication: SI PPS Health Literacy Healthy Partnerships

- Project related, disease specific Health Literacy curriculum
- Providers teach hands on health content to students

✓ Public Health Education campaign using SMS text messaging: SI textiPPS

Patient Activation

- El Centro, YMCA New Americans Welcome Center, Make the Road, JCC, Staten Island Opportunities Alliance, Island Voice

Social Determinants

- NYCHA
- Department of Education
- City Harvest/ DOH- Registered Dietician
- City Harvest- Rx for Food Referral Program
- Meals on Wheels
- Child Mind Institute
- Mayors Office of Immigrant Affairs
- Wagner College- Port Richmond Partnership
- Staten Island Immigrants Council

Healthy Neighborhoods Initiative

- Address key social determinants of health
- Neighborhoods selected by hotspotting data
- Improvement outcomes relate to 11 SI PPS Projects
- NYU Capstone Team

Cultural Competency and Health Literacy: PPS Network

Diversity and Inclusion Governance Committee

- Leaders from diverse CBO's:
  - Faith Based
  - Cultural
  - LGU
  - Social Services
- Site Champions from each PPS partner site
- Patient Advisory Council

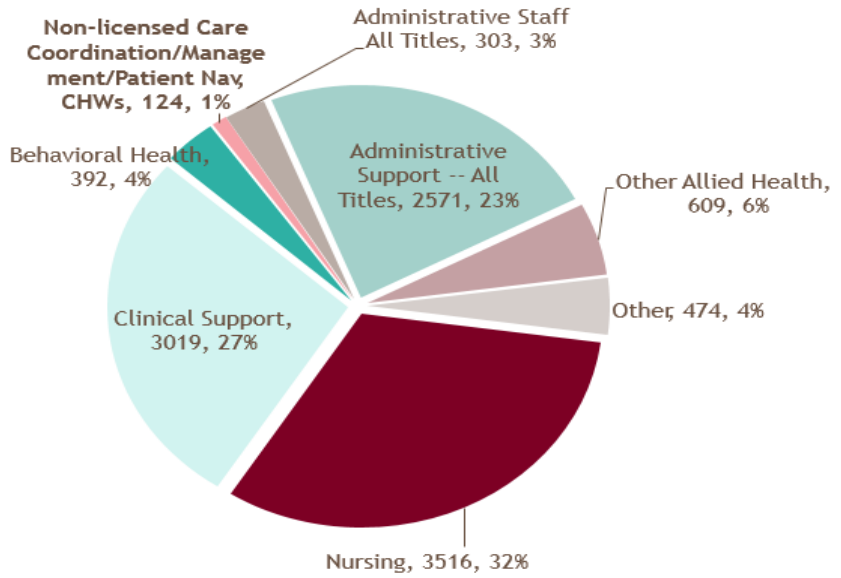
Alignment of National Best Practices at all PPS Partner Sites

- ✓ Office of Minority Health: Culturally and Linguistically Appropriate Services (CLAS Standards)
- ✓ USDOHHS National Action Plan to Improve Health Literacy
- ✓ Human Rights Campaign: Healthcare Equality Index (LGBT Health Care Equality)

PPS-wide CCHL Training Initiatives to Date

- ✓ Roll-out 1199 TEF 'Bias, Culture and Values' training- 12/22/15
- ✓ PPS-wide Medical Interpreter Training program- January 2016
- ✓ Contract with CBO Pride Center of Staten Island for PPS-wide 'LGBT Healthcare Equality Cultural Competency Training' launch January 2016

Current Workforce



- Gathered data using workforce survey tool and in-person site visits, completed on 11/20/2015
- Data collected on over 11,500 healthcare workers
- Identified 182 New Hire DSRIP related positions
- 156 jobs designated for DSRIP are in non-inpatient arena
- Based on partner interviews, growth in jobs will be in the outpatient setting over the next four years

Future State

DSRIP- Incremental Target Workforce: Initial Estimate DY1 and DY2

- Health Worker/Health Coach/Navigator: 43
- RN/LPN/NP: 36
- Office/Data Tracking Support: 27
- Peer Navigator: 23
- Social Worker: 18
- Medical Assistant: 17
- Care Manager: 7
- Health Educator: 6
- Physicians/Psychiatrists: 5

Emerging Titles

Population Health Improvement: Changing the Model of Care and Engaging the Community

The PPS created Population Health Improvement programs to focus on value and quality and move away from volume-based care model:

- Pediatric Population Improvement Program, Adult Population Health Improvement Program and Behavioral Health Improvement Program
- Contracts with previously unaffiliated physician practices
- Support achievement of PCMH recognition
- Adoption of evidence based guidelines, use of EMR, proactive care paradigm, shared care plans
- Sharing health data with the PPS data warehouse and between providers using RHIO
- Incentivized payments are based upon meeting quality milestones

Utilizing Linkages with Community Based Providers for Effective Project Implementation

Health Home at Risk: SI CARES

- Partnership with SI's Health Home Coordinated Behavioral Care and with Northwell Health Solutions

Strengthen Mental Health and Substance Abuse Infrastructure

- Collaboration with SI Partnership for Community Wellness/Tackling Youth Substance Abuse
- OASAS and Office of Mental Health

Access to Chronic Disease Preventive Care Initiative

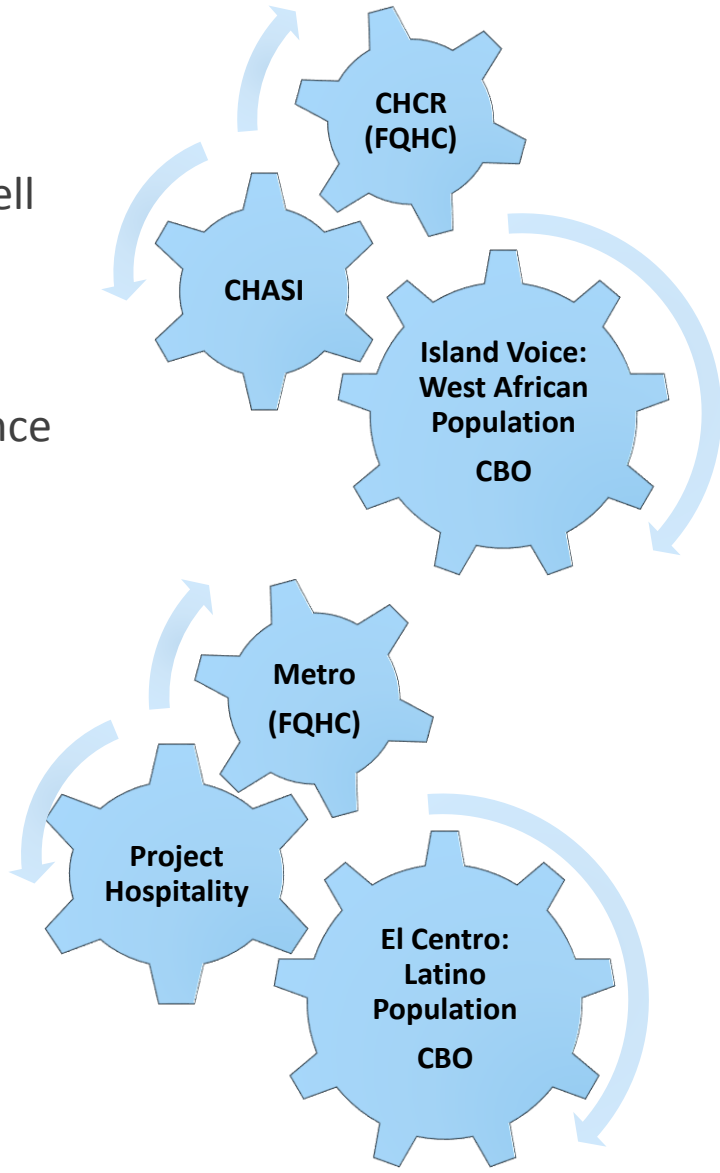
- Linkage with Borough Hall's Health and Wellness Program, Take Care NY, State Prevention Agenda

Patient Activation and Community Health Navigation

- Partnership with CHASI and Project Hospitality

Collaboration with Local Governmental Units (LGU)

- EMS, FDNY, NYC Mayor and Borough President's Office, OASAS, OMH



Health Analytics: Program Development, Performance Monitoring and Hotspotting

Development and Monitoring

- SI PPS has extensive analytic capacity using data from multiple sources to direct programmatic efforts
- Hot-Spotting conditions and disparities by geographic location
- Focus includes health literacy and diversity factors to inform recruitment of new partners, refine nature of Community Based Organization relationships, and define training needs based on area/culture served

Hotspotting Selected Ambulatory Care Sensitive Conditions (ACSC)

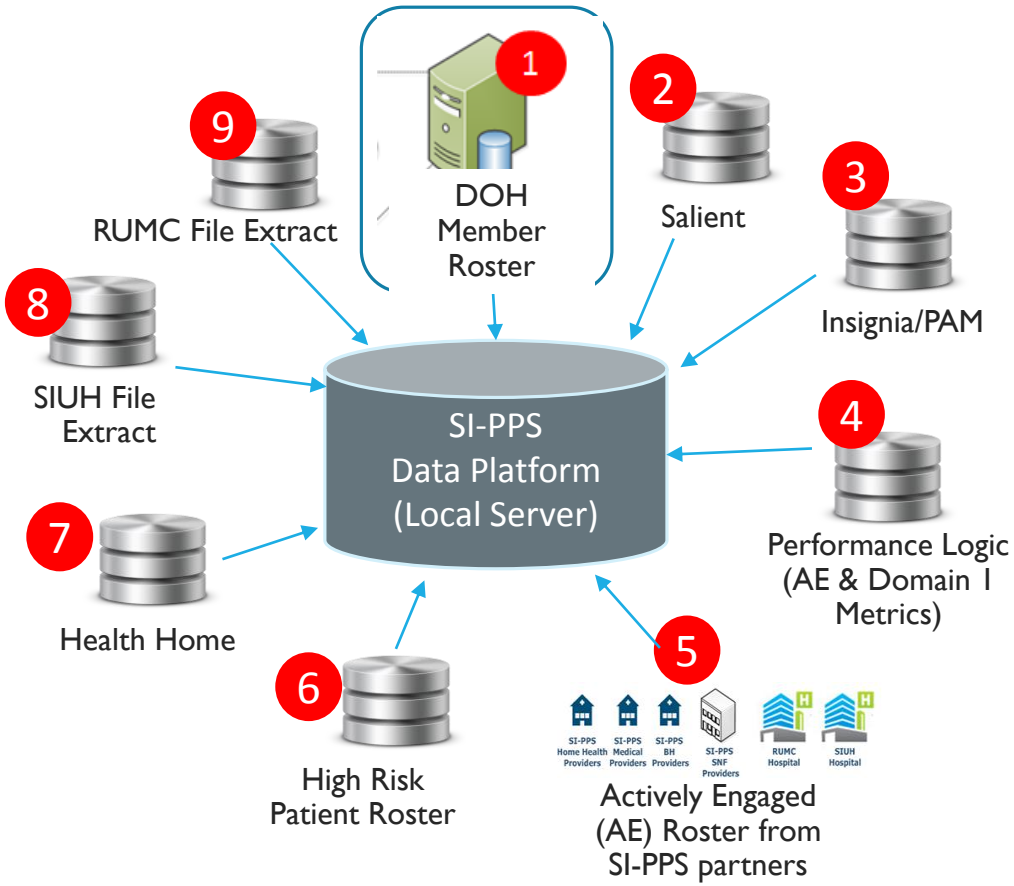
Evidence from epidemiological studies on the causes of ACSCs suggests that not all the causal factors are "under primary care provider control."

Selected ACSC Disease
Diabetes
Asthma
COPD
CHF
Hypertension
CVS

Factors outside direct physician control include:

- low socioeconomic status
- cultural background
- older age
- availability of care providers
- geographical factors (i.e. distance to hospital)

SI PPS Data Integration

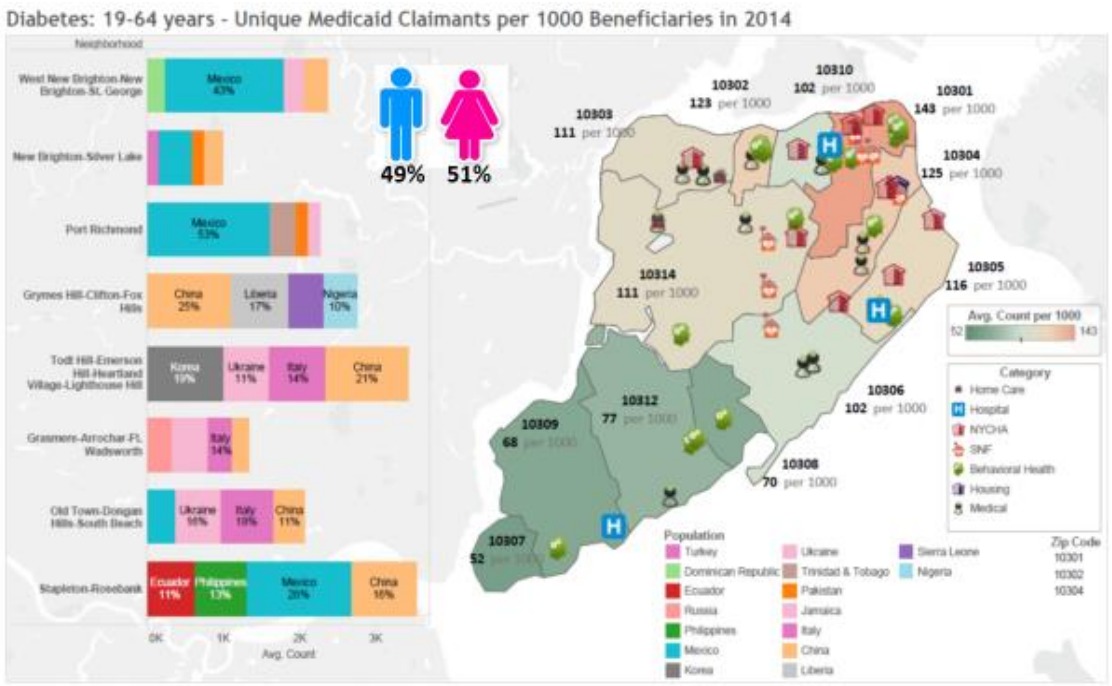


Data Source	Utilization
1, 2,4, 5, 8 SI PPS Data/Analytics Activity	• Create SI PPS master patient index (MPI) • Clinical data warehouse • Hot spotting • Build patient registry
1, 5, 7, 8, 9 Cohort –based patient registry	• 3.c.i: Diabetes management • 2.a.iii: Health home at risk • 2.b.iv: Care transition to reduce 30 day readmissions • 3.g.ii: Integration of Palliative Care into nursing homes • 2.b.vii: INTERACT
3 Project 2.d.i	Monthly data quality report and feedback to SI PPS partners
4 Domain 1 Performance Tracking (AE)	Create SI PPS master patient index (MPI)
9 MAX Series	MAX series to identify super utilizers

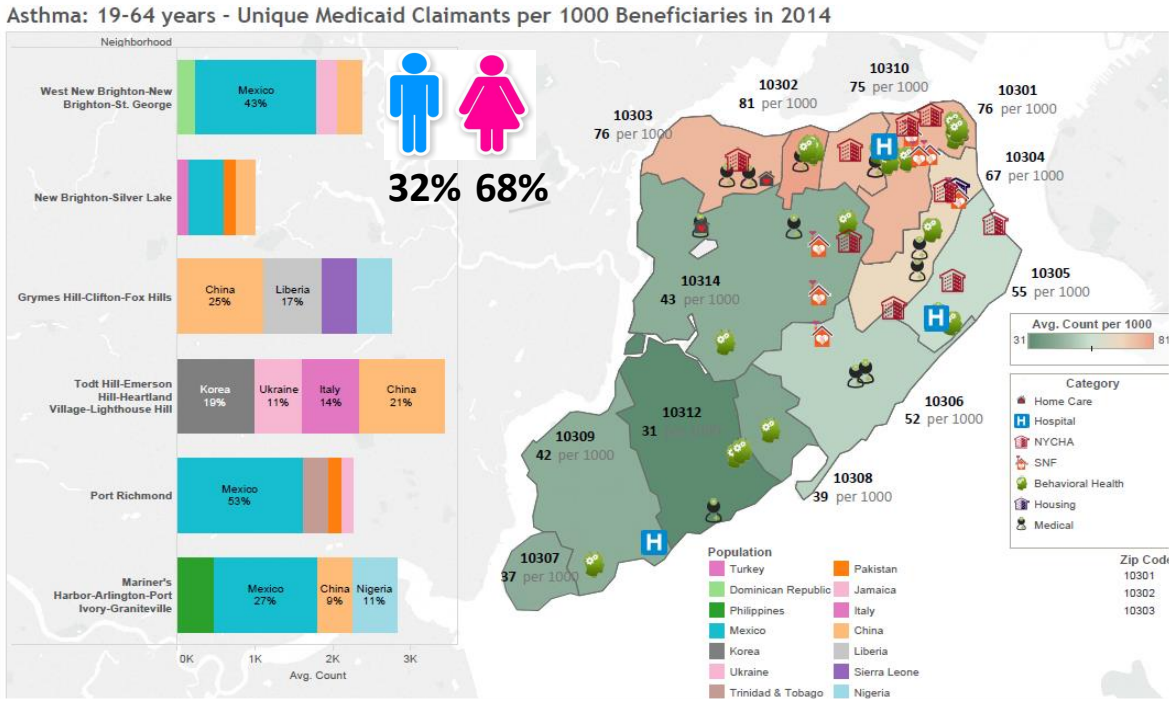
Staten Island Health Disparities
Medicaid Recipients

Data Sources:

- DOH Medicaid member roster
- Salient database
- NYS Department of Planning Data



Diabetes



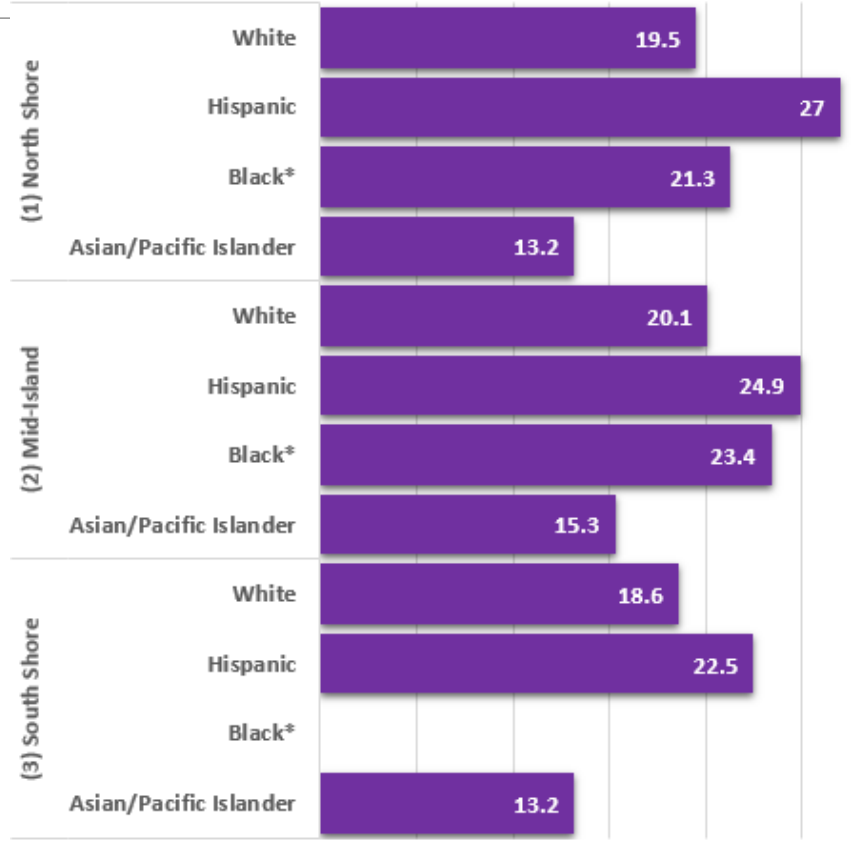
Asthma

Prevalence of obese among NYC public school students living in a Staten Island zip code, grades K-8, during the 2012-13 school year

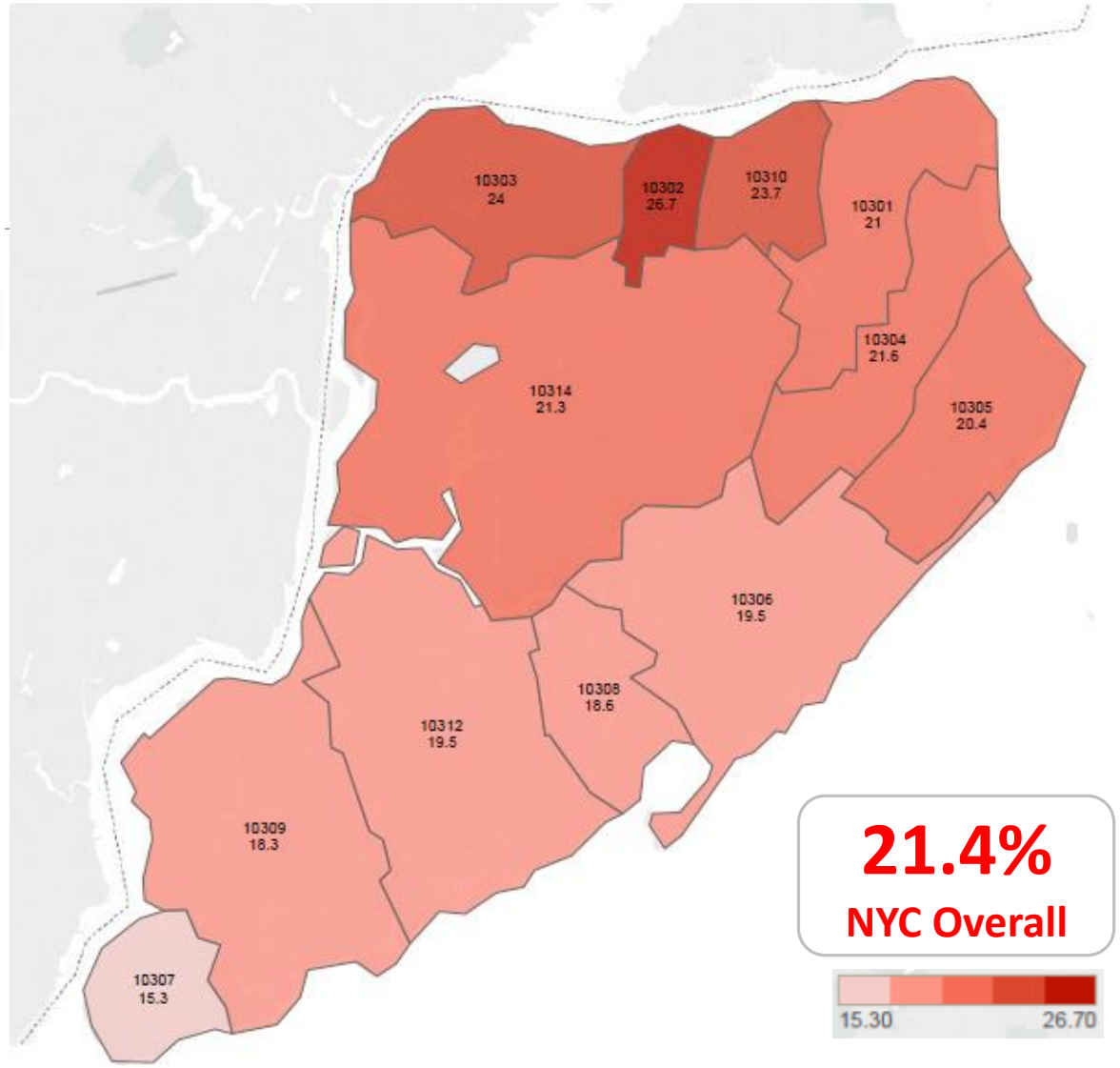
GENDER

North Shore	24.3% 20.7%
Mid Island	23.1% 18.0%
South Shore	21.0% 16.2%

Race / Ethnicity (%)



** Indicates that N<100. This estimate is unstable and has been suppressed.*

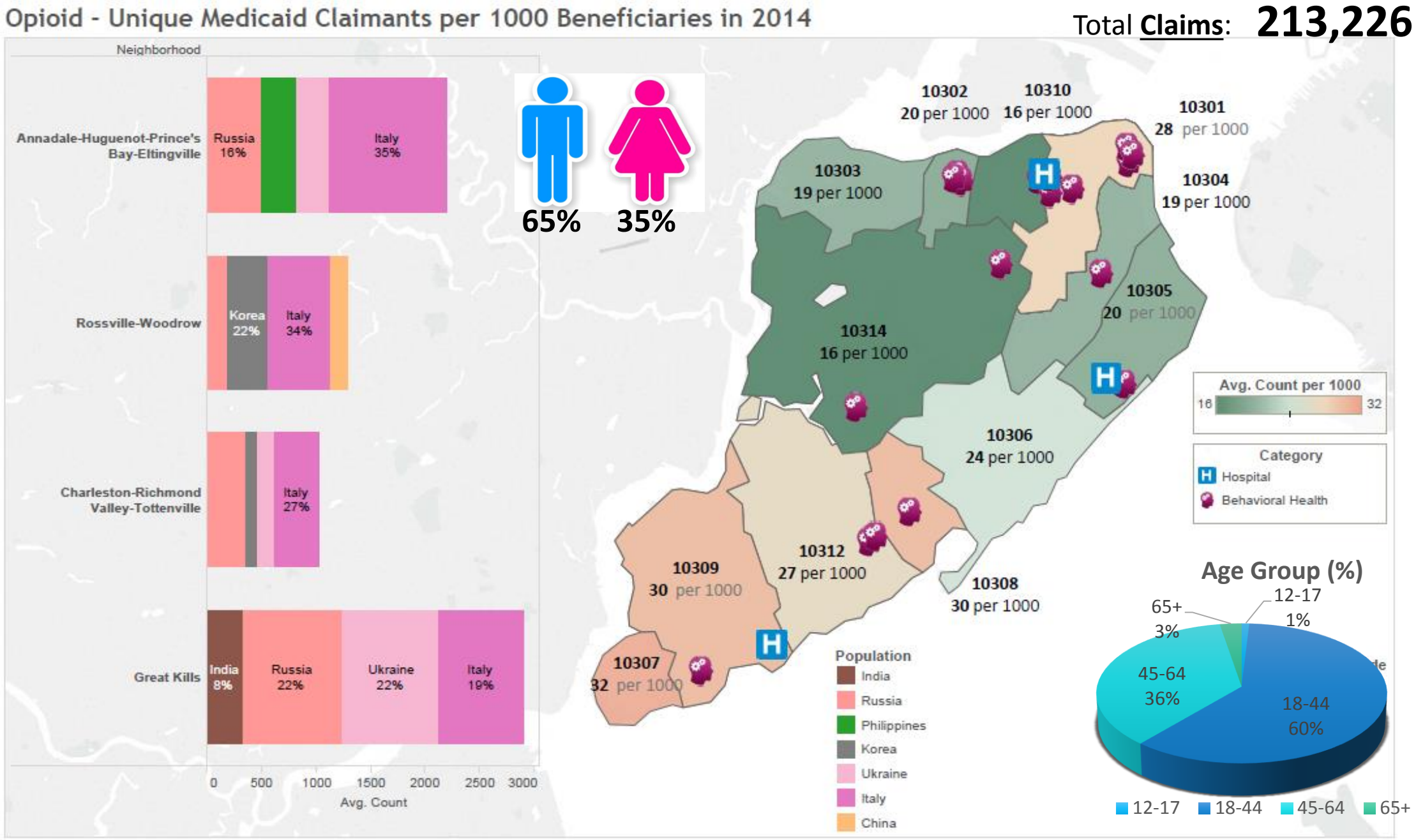


%
12.90 26.70

Grade K-8	0K	01	02	03	04	05	06	07	08
North Shore	16.20	19.50	22.80	24.60	25.20	26.70	24.90	22.80	20.10
Mid-Island	18.60	16.50	21.90	21.90	24.90	21.30	19.50	21.60	19.50
South Shore	12.90	13.80	17.70	20.10	20.40	20.40	20.10	20.70	20.40

Data Source: NYC FITNESSGRAM

Geomapping: Nation of Origin Overlay



Building Patient-Centered Medical Homes (PCMH) and Strengthening Primary Care

Staten Island has the lowest NCQA PCMH recognition rate of all NYC boroughs

Target State – NCQA 2014 PCMH Level 3

- 41 practices
- 109 primary care providers

SI PPS Strategy:

- Provide assessment & technical assistance to practices
- Support clinical integration
- Train workforce for team-based care
- Strengthen culturally and linguistically appropriate services
- Create a cross-partner learning collaborative

Evidence-based diabetes management

- Stanford Model for Chronic Disease Self-Management
- Implement evidence-based guidelines
- Create interdisciplinary care coordination teams

Care coordination for high risk patients

- Referrals to Health Home At-Risk care management agencies

Integration of behavioral health

- Screen patients for depression and substance abuse
- Co-locate behavioral health specialists
- Develop evidence-based standards of care

Project Highlights

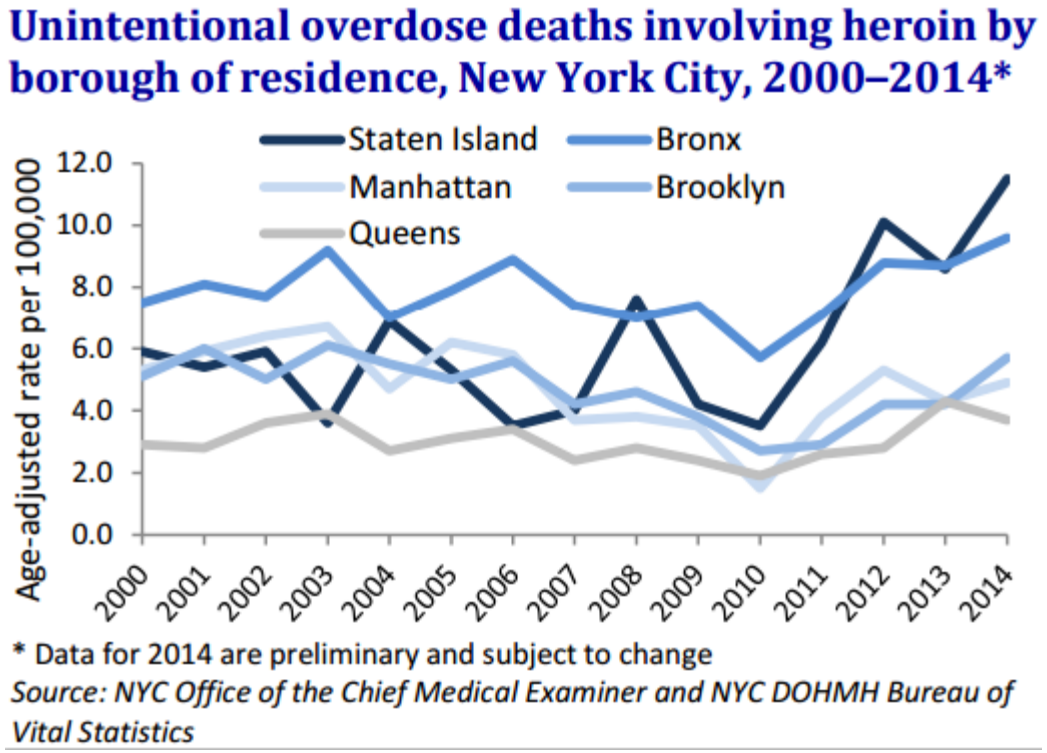
2.a.iii Health Home At-Risk Intervention Program

- 2 Health Homes and 6 CMAs have finalized agreements to provide care coordination services to target patients
- Adults and children who meet PPS approved criteria are being enrolled into program

3.a.i Integration of Primary Care in Behavioral Health Settings

- Primary Care & Behavioral Health Integration and Behavioral Health Workgroups
- Standardization of collocation, workflow and referral guidelines
- Licensure expansion and site renovations

Project Highlights



4.a.iii Strengthen Mental Health and Substance Abuse Infrastructure

- Engaged multiple treatment providers, government agencies, CBOs, and other stakeholders
- Key informant interviews, focus groups, and claims analyses used to understand existing MEB services, community needs, barriers to care
- Partnerships with government agencies (e.g. NYC DOHMH) to align mental, emotional, behavioral (MEB) priorities

3.a.iv Development of Withdrawal Management Services

- 8 substance abuse providers enhance access to ambulatory detox in collaboration with OASAS and NYSDOHMH

Pilot program: Diversion of patients with less severe withdrawal symptoms from ER/IP

- 24/7 call center being developed
- Licensed provider and peer engagement resources

Long Term and Continuing Care Projects Highlights

2.b.vii Skilled Nursing Facility- INTERACT

- Two trainings completed in 2015 for all SI PPS partners:
- Continuing Care Leadership Coalition (CCLC) provided training focused on communication tools at 7 SI PPS Partner Sites
- Telemedicine Pilot

3.g.ii Palliative care training assessment for all 10 nursing homes complete

- Using the National Consensus Project Clinical Practice Guidelines for Palliative Care
- On-site palliative care performance improvement process

2.b.viii Home Care

- INTERACT training completed
- Hospital collaboration to improve discharge process

Telemedicine Pilot

Long-term Care Workgroup identified the need to address transfers that occur in the late evening and weekend hours

- Launched the telemedicine pilot allowing nursing home staff to initiate a telemedicine session with board certified emergency medicine physicians
  - Coverage hours: 5pm on Friday-> until 7am Monday
  - Medical evaluations via videoconferencing for patients include:
    - Evaluation
    - Video-assisted examination
    - Treatment plan
    - Discussion with the patient, nurse and/or caregiver
    - EMR documentation

Developing Competencies and Training Future Workforce

SI PPS utilized partner Workforce survey to identify:

- Training constraints: space/technology/staff coverage
- Current training resources
- Training gaps
- Challenges

DSRIP 101 Training:

- Baseline on how DSRIP impacts the healthcare system and the workforce
- Developed in conjunction with 1199 TEF, January 2016
- All training to be built upon this program

1199 TEF:

- Developing Community Health Worker curriculum with College of Staten Island, Fall 2016
- 1199 TEF Training Consultant to begin working with SIPPS, January 2016

Workforce Committee:

- Committee co-chairs: Rebecca Hall, 1199 TEF and Janice Maye, Camelot

Questions? Visit us at www.statenislandpps.org