Alliance for Better Health Care, LLC

ED care triage for at-risk populations (2.b.iii)

R1 The IA recommends the PPS develop a training strategy to address the patient lack of knowledge regarding the shift to primary and preventive care away from the ED.

Response:

Background:

Alliance organizational structure was designed to implement our 11 DSRIP projects. Partner led Collaborative were formed to complete all DOH dictated Milestones. Alliance has a dedicated ED care triage project manager.

Alliance employs a part-time Communications Director who has been working with the project manager to increase patient knowledge regarding the need to help those seeking care to think first about primary care facilities rather than the ED.

Current State:

Marketing and communication activities have failed to achieve patient education objectives.

Analysis:

Alliance does not have adequate marketing and communication resources in place to address the patient lack of knowledge regarding the shift to primary and preventive care and away from the ED. The current resource (one person – shared with IHANY) is inadequate to do the work necessary for a successful outreach and education plan.

Alliance partners are not adequately trained to address this patient lack of knowledge at the point of service.

Desired Future State:

An informed, educated, and empowered patient population that makes appropriate reckons about where to seek health care services.

Actions:

Alliance will add additional marketing and communications resources to develop and implement a broader messaging campaign. The campaign will create brand awareness for The Alliance among community providers and patients, and will include public service messaging consisting of TV, Radio and/or print ads to promote the advantages of shifting away from use of the ED and towards primary care. The Alliance will provide our network partners with

handouts, flyers, posters, pamphlets and other culturally appropriate educational materials that are complaint with the health literacy status of the target audience.

The Alliance will implement the incentive-Fast Start, and Long-Term Incentive programs. Alliance has been aggressively educating the incentive fund working group of clinicians, quality, and financial personnel, as well as the full Finance Committee, Board of Managers and Members regarding the shift to primary and preventive care away from the ED, and will provide fiscal incentives to care providers who meet goals that align with reductions of unnecessary ED use.

Alliance will refine the messaging for these incentive programs, which focuses on the shift to primary care and preventive care and away from the ED, with our PAC at our upcoming PAC meetings, and with partners and patients through community listening sessions and meetings with care providers.

Alliance has hired a new Medical Director whose role will include provider education, positioning them to effectively educate patients at the point of service.

Specific Objectives:

Add marketing and communications resources to develop and implement a multimedia campaign.

Implement marketing and communications campaign

Incentive strategy sessions, and communications feedback with PAC, partners, and community members.

Hire Medical Director.

Care transitions to reduce 30-day readmissions (2.b.iv)

R2 The IA recommends the PPS develop a strategy to centralize the approach it is taking across the network to address care transitions and include behavioral health and psychosocial issues.

R3 The IA recommends the PPS educate their network partners about the available models of transitions of care.

Response:

Background:

The Alliance's organizational structure was designed to implement our 11 DSRIP projects. Partner led collaboratives were formed to complete all DOH dictated Milestones. The Alliance has a designated Care Transitions project manager.
Alliance historically employed a part-time Chief Medical Officer (shared with IHANY) and contracted with a consultant for IT. These resources have been working with the project manager to drive adoption of clinical best practices, and develop tools to facilitate care coordination.

Current State:

Existing resources and a focus on project implementation have failed to produce best practice adoption or fully educate partners about new models of care that will reduce preventable readmissions.

Analysis:

Alliance's network partner's understanding about the different models of care was negatively impacted by our reliance on a part-time interim CMO. Full time Alliance employed clinical leadership is an integral component of an effective strategy to educate partners and focus efforts on emerging clinical trends and best practices.

Alliance's initial flow of fund orientation, focused on project implementation, did not create sufficient financial incentives for partners to make the required changes to clinical practices and protocols that align with emerging clinical trends and best practices.
Reflecting the shift of DOH funding from reporting to performance, our funds flow emphasis needs to shift as well. Our analytics team has identified a set of near-term opportunities through the balance of the measurement year ending June 30, 2017, which forecasts our gap-to-goal outcome performance opportunities. With a provider led working group of clinicians, quality, and financial personnel, we have identified key measure clusters on which we will focus in the near term, and will expand our performance focus in measurement year 3.

Alliance did not employ a full-time CIO, and as a result there was a lag in the implementation of IT tools to facilitate care coordination.

Desired Future State:

A healthier population, with more appropriate use of health care resources, as measured by meeting DOH identified performance goals.

An engaged partner community, actively sharing and embracing best practices in the reduction of preventable readmissions.

Actions:

Alliance will add a full-time Medical Director who will focus on educating providers and our new CEO is a physician.

Alliance will facilitate forums to share evidence based best practice tools such as high-risk readmission screens, health literacy assessments tools, early warning identification processes and SBAR (Situation, Background, Assessment, Recommendation) and other communication tools to identify medical, behavioral health and psychosocial needs.

Alliance is making a Strategic investment in shifting emphasis to achieving outcome measure performance objectives. The Alliance has re-allocated $2,000,000 from operating funds and our strategic reserve to fund partners' implementation of innovative initiatives through the balance of the measurement year ending June 30, 2017 (the "Fast-Start Incentive Program") toward meeting performance gaps that had historically received insufficient attention. The program increases focus on reducing Potentially Avoidable Readmission, including approved funding and technical infrastructure to promote warm handoffs between hospitals and community providers.

Alliance is developing the Long-Term Incentive program focused on clusters encompassing the comprehensive set of outcome measure. Funds (DSRIP budget categories) will be re-allocated to maximize the Incentive fund, to fully emphasize the performance goals of the program. Our Medical Director will lead a working group of clinicians, community based organizations, quality leaders, and financial personnel in the development of our Long-Term Incentive program. This effort will maximize performance against DSRIP objectives thereby improving the health of our population.

Alliance will hire a full-time CIO.

Alliance will launch a Care Management system and secure messaging service that will enable real time communication, ensure warm handoffs and facilitate sharing of patient care plans across the continuum of care.

Alliance will continue to provide training on models of transitions of care including; INTERACT, Bridge Model, Coleman Model, Naylor Model, BOOST Model, and Project RED.

Alliance will participate in the NYS DOH sponsored MAX Series.

Alliance for Better Health Care in collaboration with the Innovative Health Alliance of New York (IHANY) will host a town hall educational session for our network partners called Delivery System Transformation in a Clinically Integrated Network with Dr. Amy Boutwell as the featured speaker.

Specific Objectives:

- Launch a Care Management system and secure messaging service.
- Participate in MAX Series.
- Re-allocate Loss-of-Revenue budgeted funds to Incentives.
- Implement Fast-Start Incentive Strategy.
- Implement Long-Term Incentive Strategy.
- Achieve 10% gap-to-goal performance improvement for key goals in measurement year 2
- Hire a full-time Medical Director to drive clinical alignment and partner engagement.
- Hire a full-time CIO to drive technologies that support care coordination.
- Hire five community health workers, and two care managers to assist in the coordination of existing processes.

Hospital-home care collaboration (2.b.viii)

R4 The IA recommends the PPS develop a strategy in conjunction with home health agencies to align the documentation in order to prevent miscommunication and missing information.

R5 The IA recommends that the PPS workforce committee develop a strategy to recruit home health-aids.

Response:

Background:

The Alliance's organizational structure was designed to implement our 11 DSRIP projects. Partner led collaborative Collaboratives were formed to complete all DOH dictated Milestones.

Alliance has a designated Care Transitions project manager.
Alliance historically employed a part-time Chief Medical Officer (shared with IHANY) and contracted with a consultant for IT. These resources had been working with the project manager to align documentation between hospitals and home-care agencies.

Current State:

Project implementation activities have failed to prevent miscommunication between hospitals and home health agencies.

Analysis:

Alliance's network partner's adoption of the INTERACT model was negatively impacted by our reliance on a part-time interim CMO. We determined that to be effective our partners needed to increase interaction with the community, emphasizing the value of improved collaboration across legacy silos.

Alliance did not employ a full-time CIO, and as a result there was a lag in the implementation of IT tools to facilitate standardization of documentation among home-care agencies and effective communication with hospitals.

Alliance's initial flow of fund orientation, focused on project implementation, did not create sufficient financial incentives for partners to make the required changes to clinical practices and protocols that align with emerging clinical trends and best practices.

Reflecting the shift of DOH funding from reporting to performance, our funds flow emphasis needs to shift as well. Our analytics team has identified a set of near-term opportunities through the balance of the measurement year ending June 30, 2017, which forecasts our gap-

to-goal outcome performance opportunities. With a provider led working group of clinicians, quality, and financial personnel, we have identified key measure clusters on which we will focus in the near term, and will expand our performance focus in measurement year 3.

Desired Future State:

A healthier population, with more appropriate use of health care resources, as measured by meeting DOH identified performance goals.

A highly coordinated and effective hospital to home care process with adequate staffing of home health aides.

Actions:

Alliance will add a full-time Medical Director who will focus on educating providers and our new CEO is a physician.

Alliance will conduct cross continuum INTERACT leadership training sessions for CBOs, Hospitals and Primary Care offices so that these community providers and organizations have leadership support to implement INTERACT tools consistently across all care settings.

Alliance will introduce patient education “zone sheets” across the care settings to ensure a consistent approach to patient education.

Alliance will continue to offer hospitals the opportunity to augment their existing care management resources (financial, people, products or processes) based on analytics provided by Alliance used to evaluate their success with performance and patient outcomes.

Alliance has now hired a full-time CIO.

Alliance will launch a Care Management system and secure messaging service that will enable real time communication, ensure warm handoffs and facilitate sharing of patient care plans across the continuum of care.

Alliance will implement its’ Fast-Start Incentive, and Long-Term Incentive programs that will enhance partner focus on improved outcomes.

Alliance's Workforce Committee will partner with committee member Schenectady County Community College to increase the number of community health workers.

Specific Objectives:

- Launch a Care Management system and secure messaging service.
- Re-allocate Loss-of-Revenue budgeted funds to Incentives.
- Implement Fast-Start Incentive Strategy.
- Implement Long-Term Incentive Strategy.
- Achieve 10% gap-to-goal performance improvement for key goals in measurement year 2
- Hire a full-time Medical Director to drive clinical alignment and partner engagement.

EXPANSION of ASTHMA HOME-BASED, SELF-MANAGEMENT PROGRAM

R6 The IA recommends the PPS workforce committee develop a strategy to recruit certified asthma educators.

R7 The IA recommends the PPS develop a standard curriculum to train community health workers in asthma home-based, self-management.

R8 The IA recommends the PPS develop a strategy to engage their patient population in this project.

Response:

Background:

Alliance's organizational structure was designed to implement our 11 DSRIP projects. Partner led collaborative teams ("Collaboratives") were formed to complete all DOH dictated Milestones ("requirements"). Alliance has a designated Asthma Expansion of Home-Based Care project manager.

Alliance did not meet the 3.d.ii patient engagement targets in DY1.

Current State:

A total of 10 new AE-C's have been certified, with more in the pipeline.

The *Asthma Education for the Community Health Worker* program from the Association of Asthma Educators has been adopted as the curriculum to train community health workers ("CHW").

Analysis:

Alliance's asthma project workgroup recognized the need for additional certified asthma educators (AE-C) engaged with the PPS. When we started to recruit, we found that there were simply not enough AE-C in the community. We therefore shifted our strategy from one where we would recruit existing educators (who didn't exist) to creating the educators. The Alliance offered a 2-day Asthma Educator Program twice in 2016. A total of 86 licensed professionals from across the region participated.

Alliance's asthma project workgroup recognized the need for additional CHWs to support the efforts of certified asthma educators. However, after determining there was an insufficient pool from which to recruit, our strategy shifted to increasing the number of CHWs trained to support AE-Cs. We therefore offered a 3-day program that was conducted in January 2017 with a total of 15 CHW's in attendance.

The asthma project workgroup has adopted the *Asthma Education for the Community Health Worker* program from the Association of Asthma Educators as the curriculum to be used to train CHW's.

Patient engagement efforts were hampered by the lack of project implementation contracting prior to Fall 2016, and as a result Alliance did not meet the patient engagement targets in DY1. We did achieve the target for DY2Q2 (104%) and DY2Q3 achieved 99%, and is trending toward meeting the cumulative DY2Q4 target.

Desired Future State:

Sufficient asthma educators and supporting CHW resources, and engaged patients who are managing their asthma well.

Actions:

The Alliance will continue to host and coordinate the 2-day Asthma Educator Program approved for a total of 14.75 hours of continuing education. The training will be delivered by a multidisciplinary team of professionals including: RRT, PharmD, PhD, and MD with no fewer than six of these individuals holding the AE-C credential.

Alliance will extend our contract with Kettering National Seminars to conduct a 2-day AE-C exam review. Kettering National Seminars is nationally recognized as a health care credentialing exam specialist for various professional examinations. This program is approved for a total of 10 hours of continuing education. Alliance will continue to host and coordinate the 2-day AE-C exam review. All participants will be required to sit for the AE-C exam within 90-days of completing the review course.

Alliance will continue to offer the *Asthma Education for the Community Health Worker* program from the Association of Asthma Educators to train CHW's.

We will work with our partners and CBO's to develop methods to identify and extract patients engaged, from the various EHR systems in place.

Specific Objectives:

Offer asthma educator training twice in 2017 (April and September).

Offer 2-day AE-C exam review twice in 2017 (April and September).

Offer *Asthma Education for the Community Health Worker* training Fall 2017.

Achieve DY2Q4 cumulative 3.d.ii patient engagement target.

R9 The IA recommends that the PPS develop an action plan to address the contracting with CBOs.

Response:

Background:

Alliance's Fund Flow strategy initially was limited to a Project Fund focused on the implementation of projects and completion of DOH dictated requirements. Collaborative teams were formed by Alliance's partners, along naturally occurring patient service areas lines, (hubs). Alliance Payments to providers for this project implementation activity are performance based, focusing on meeting targets including partner and patient engagement including the depth and breadth of Collaborative Participants to encourage partner engagement across all projects.

Current State:

We completed much of our project implementation contracting in the Fall of 2016. The Fund Flow and Patient Engagement detail of this MPA response (action plan), reflects the contracting completed after the MPA snapshot DY2Q2. We now have executed and implemented many CBO contracts through our "hubs" and while this information was not reflected in the MPA, it has been submitted to the IA.

Analysis:

Alliance has determined that personnel changes, and a pivot to Incentive Fund allocations and a movement away from Project Fund allocations will likely further enhance CBO engagement. Adding a leadership position focused on CBO engagement is necessary to get CBO engagement where we want it to be.
Reflecting the shift of DOH funding from reporting to performance, our focus is shifting as well. Our analytics team has identified a set of near-term opportunities through the balance of the measurement year ending June 30, 2017, which forecasts our gap-to-goal outcome performance opportunities. With a provider led working group of clinicians, quality, and financial personnel, we have identified key measure clusters on which we will focus in the near term. The Incentive emphasizes the role of community based providers and physicians, and de-emphasize the role of hospitals.

Desired Future State:

An actively participating CBO population across all projects.

Maintain existing project focus and resources.

Actions:

Implement a strategic pivot to Incentive funding that emphasizes the role of community based providers and physicians, and de-emphasizes the role of hospitals.

Alliance will establish a CBO Executive Committee (CEC) to facilitate and support CBO engagement.

Alliance will develop regionally based CBO Collaboratives (RSC) to facilitate and support CBO engagement.

Alliance will use Collaboratives and workgroups of diverse provider types to implement projects, while simultaneously expanding beyond project implementation (the Project Fund), to directly focus on outcome measures (the Incentive Fund). The premise of the Incentive Fund is that the most effective interventions emphasize the role of community based providers and physicians, and de-emphasize the role of hospitals.

Alliance will allocate $2,000,000 for incentives to partners implementing the identified Fast-Start initiatives through the balance of the measurement year ending June 30, 2017. Over $1,000,000 of this program is earmarked for CBO payments. This “Fast Start” Incentive program will be closely monitored and adjusted to both maximize current performance, and inform the development of Alliance’s Long Term Incentive program.

Alliance is developing a Long-Term Incentive program around clusters that encompass the comprehensive set of outcome measures and will shift budgeted funds from Loss of Revenue to Incentives to maximize engagement.

We will focus our provider led incentive working group of clinicians, quality, and financial personnel on developing a program that maximizes partner engagement.

Alliance will extend existing project implementation contracts with CBOs through DY3, and will identify and engage CBOs to participate in activities identified to close the gap-to-goal on outcome measures (Incentive Fund Flow methodology).

Alliance is adding staff dedicated to increasing CBO engagement

Specific Objectives:

Establish a CBO Executive Committee (CEC).

Establish regionally based CBO Collaboratives (RSC).

Execute DY3 Project Fund contracts.

Execute DY3 Fast-Start Incentive Fund contracts.

Execute DY3 Long-Term Incentive Fund Contracts.
Add Vice President CBO Engagement position to Alliance leadership team.

R10 The IA recommends that the PPS develop a strategy to address how it will measure the effectiveness of their CCHL outreach efforts across the PPS network.

R11 The IA recommends that the PPS develop a strategy to better address the CCHL training needs of its partners.

R12 The IA recommends that the PPS develop metrics to assess its most effective Strategies to engage Medicaid members and the uninsured.

Response:

Background:

The Alliance developed and submitted its CCHL strategy to the IA DY1Q3 which included conducting organizational assessments of our partners to focus training development activities. However, at that time Alliance did not have resources in place dedicated to the implementation of its CCHL strategy.

Current State:

The CCHL taskforce and the Alliance Workforce Committee are developing a general CCHL training curriculum for the entire the PPS community, in collaboration with another PPS in the region.

Analysis:

The Alliance has not effectively implemented its' CCHL strategy, and only recently was able to recruit a full-time leader of the CCHL program.

The Alliance has not yet completed any individual organizational CCHL training needs assessments.

Actions:

Alliance will initially conduct organizational assessments at our two FQHC locations (Hometown Health and Whitney Young) as pilot sites that include organizational competence; staff awareness of cultural competency and health literacy; and patient satisfaction surveys.

Alliance's CCHL taskforce will review completed pilot site assessments to identify specific CCHL training needs.

Alliance will develop and implement a CCHL training plan at the pilot sites.

Alliance will hire a CHW supervisor and 4 CHWs to partner with existing community based organizations to expand efforts to connect individuals to insurance and additional resources, and do capture data regarding CC among providers and HL needs of members.

Alliance will conduct community based listening sessions, and will review and assess provider based patient satisfaction surveys to obtain feedback regarding our efforts.

Alliance's CCHL taskforce will collaborate with our Workforce Committee to monitor the effectiveness of all CCHL training components conducted at our partner sites.

Specific Objectives:

Meet performance targets:

- 10% year over year Improvement in PAM scores demonstrated by Flourish data
- 10% year over year Decrease ER visits of uninsured demonstrated by DOH findings
- 10% year over year Increase preventive; primary care; and behavior health care access demonstrated by claims data
- 10% year over year Reduce hospital readmissions demonstrated by claims data
- Quarterly review of existing patient satisfaction surveys

R13 The IA requires the PPS to assess the status of its network partners' involvement in VBP.

R14 The IA requires that the PPS establish a plan to further educate and support their partners move towards VBP arrangements.

Response:

Background:

Initially PPSs were envisioned as contracting entities for network partners. The Alliance strategically aligned with IHANY, an ACO, to fulfil this contracting role. IHANY has been successful in executing one such contract with an MCO and is working on others. In addition there are other entities in the region that are creating MCO contracting products, and value based MSO services that align with our shared goal of migrating the community to value based care models.

Current State:

DOH has pushed back the due date on all VBP related requirements and the DSRIP program focus has shifted from an expectation of that the PPS would create VBP contracting through the MCOs, to one in which the PPS would educate, coordinate and facilitate value based contracting along many vectors.

The Alliance completed a review of Member involvement in VBP arrangements during the Fall of 2015, and has been a participant in conversations with medical groups, MCOs, and of course our members, as we have worked to understand and then evangelize the opportunities for value based contracting in the community.

Analysis:

Our sample size for the 2015 VBP survey is too small and too dated to be useful today, and our conversations provide only anecdotal evidence of the region's readiness to engage in value based contracting. Nonetheless, it is clear that our region has neither an MCO nor a care delivery organization that has yet made a firm commitment to migrating a significant portion of their business to value based models.

Our pivot away from a project focus to an Incentive focus will pull our network providers into a VBP oriented experience, focusing on reductions in fee-for-service claims, which translate into incentive funds to be shared among partners who have met their objectives. This strategy, combined with a new emphasis on driving MCOs and care providers toward value based care will provide additional incentive for the region to continue the traverse toward value based payment models.

Desired Future State:

A partner population educated about VBP and comfortable operating in a VBP environment.

Actions:

Alliance has re-allocated $2,000,000 to fund partner implementation of innovative initiatives through the balance of the measurement year ending June 30, 2017 (the "Fast-Start Incentive Program").

Alliance will develop and implement a Long-Term Incentive program focused on clusters encompassing the comprehensive set of outcome measure. Funds will be re-allocated to maximize the Incentive fund.
We will develop a thorough VBP survey and administer it to a sufficient sample size to objectively assess the status of Alliance's network partner involvement in VBP.

Alliance will develop a VBP curriculum, and deliver the VBP training to our Members, Board of Managers, community providers, and MCO staff. This VBP training and education will be coordinated where possible with adjacent PPSs, and will enlist the subject matter expertise of our MCO network partners, or MCO partners from other regions that have been more successful in migrating to the new payment models.

Specific Objectives:

Develop and administer a VBP needs assessment.

Develop a VBP curriculum.

Roll out training to Members.

Roll out training to Managers.

Roll out training to all partners.

Dedicate staff to VBP education, facilitation, coordination and evangelism.

R15 The IA requires the PPS to develop an action plan to increase partner engagement, in particular for PCPs and Behavioral Health partners.

R16 The PPS must develop a detailed plan for engaging partners across all projects with specific focus on Primary Care, Mental Health, Substance Used Disorder providers as well as Community Based Organizations (CBOs). The Plan must outline a detailed timeline for meaningful engagement.

The Plan must also include a description of how the PPS will flow funds to partners so as to ensure success in DSRIP.

The PPS must also submit a detailed report on how the PPS will ensure successful project implementation efforts with special focus on projects identified by the IA as being at risk.

Response:

Background:

Alliance's Fund Flow strategy initially was limited to a Project Fund focused on the implementation of projects and completion of DOH dictated requirements. Collaborative teams were formed by Alliance's partners, along naturally occurring patient service areas lines, (hubs). Alliance Payments to providers for this project implementation activity are performance based, focusing on meeting targets including partner and patient engagement. Financial awards to these Collaboratives were sized based on several criteria including the depth and breadth of Collaborative Participation to encourage partner engagement across all projects.

Current State:

We completed much of our project implementation contracting in the Fall of 2016. The Fund Flow detail of this MPA response (action plan), reflects the contracting completed after the MPA snapshot DY2Q2.

Our governance structure reflects the diversity of provider types including Committee representation by PCPs, BH providers, CBOs, and SUD providers.

Analysis:

Partner engagement in Alliance's Board structure is strong, consisting of our Member representatives, two independent practitioners, one of the region's largest private physician groups, and a representative of our PAC, as well as over 50 different partners who serve on one or more governance committees.

Reflecting the shift of DOH funding from reporting to performance, our focus is shifting as well. Our analytics team has identified a set of near-term opportunities through the balance of the

measurement year ending June 30, 2017, which forecasts our gap-to-goal outcome performance opportunities. With a provider led working group of clinicians, quality, and financial personnel, we have identified key measure clusters on which we will focus in the near term. The Incentive emphasizes the role of community based providers and physicians, and de-emphasize the role of hospitals.

There are approximately 519 primary care providers (PCPs) in our region that have attributed Medicaid beneficiaries. Over 92% of these providers are open to new Medicaid beneficiaries. Of these 519 PCPs, 254 also participate in overlapping PPSs. In addition, the network has 573 specialists and 257 hospital based specialists. Our five Member organizations include three large hospital systems (SPHP, Ellis, and SMHA) and two FQHCs (Whitney M. Young Jr. Health Center and Hometown Health Center), all of which employ both primary care and behavioral health providers.

Desired Future State:

An actively participating partner population across all projects, representative of a diverse set of provider types, with intentional engagement of primary care and behavioral health providers.

Actions:

Alliance will use Collaboratives and workgroups of diverse provider types to implement projects, while simultaneously expanding beyond project implementation (the Project Fund), to directly focus on outcome measures (the Incentive Fund). The primary objective of this pivot to incentive funding is to improve the health of our population as determined by performance improvement against a comprehensive set of outcome measures representing all our DSRIP projects. The premise of the Incentive Fund is that the most effective interventions emphasize the role of community based providers and physicians, and de-emphasize the role of hospitals.

We will allocate $2,000,000 for incentives to partners implementing a set of initiatives through the balance of the measurement year ending June 30, 2017. This “Fast Start” Incentive program will be closely monitored and adjusted to both maximize current performance, and inform the development of Alliance’s Long Term Incentive program.

Alliance will develop a Long-Term Incentive program around clusters that encompass the comprehensive set of outcome measures and will shift budgeted funds from Loss or Revenue to Incentives to maximize engagement.

We will focus our provider led incentive working group of clinicians, quality, and financial personnel on developing a program that maximizes partner engagement – especially in the areas of behavioral health and primary care, as these domains form the foundation of a healthy population.

Specific Objectives:

Hire a full-time Medical Director of Public Health to drive clinical alignment and partner engagement. This leader will have both behavioral health and primary care training, and will ideally have an MPH as well.

Create a new VP position focused exclusively on CBO engagement.

Create of a new director position focusing on PCP engagement.

Hire staff to specifically engage the practices and provide services, from one-on-one and team consulting, to hands-on activities.

Extend Project Fund contracts through DY3.

Implement Fast-Start Incentive program.

Implement Long-Term Incentive program.

R17 The PPS is required to submit a report that describes the overall strategic organizational approach to DSRIP and how the PPS is currently resourcing and will resource going forward this approach.

Response:

Background:

Our organizational structure was designed to implement 11 DSRIP projects. Partner led collaboratives were formed to complete all DOH dictated Milestones. The Project Fund Flow methodology linked partner payments to the completion of requirements, including partner and patient engagement commitments. Payments to Partners were adjusted based on bi-annual performance as determined by DOH. This aligns with the basic premise of DSRIP: project requirement completion will cause the 10% year-over-year performance improvement on DOH outcome measures, and the result will be a healthier population, reduced acute care utilization, and reduced overall cost (The Triple Aim).

Current State:

Alliance has demonstrated strong performance against DOH dictated organizational requirements (building the infrastructure for operating a PPS).

We completed much of our project implementation contracting in the Fall of 2016. The Fund Flow detail of this MPA response (action plan), reflects the contracting completed after the MPA snapshot DY2Q2.

Communication engagement activities have failed to achieve some objectives, and we have yet to facilitate the important shift of focus for our partners from project reporting to clinical performance.

Analysis:

The Alliance is a start-up PPS and therefore has not been able to take advantage of existing infrastructure, staff, or IT resources of a parent organization. This is good (we have agility and a true focus on serving our community) and bad (we had to start from scratch). In addition, our senior leadership for the initial ~ 30 months of DSRIP was shared with IHANY, a MSSP Accountable Care Organization that was created by two of our five Members (owners). While the shared staff and physical space provided some fiscal advantage during the launch of both companies, there were also unintended consequences that reduced the PPS team's ability to focus on DSRIP priorities. A key challenge, in retrospect, was a conflation of the strategic goals of the ACO and the PPS. While convergent, the strategic goals of these organizations are not identical, and with the same leadership, governed by separate Boards with some overlapping members, a single long-term strategy was developed to merge the work of the PPS into IHANY

– creating a contracting entity that would negotiate value based contracts with MCOs on behalf of PPS participants. Subsequently, DOH modified its' position and clarified that VBP contracting with PPS participants would be done through the MCOs, with PPS facilitation.

Reflecting the shift of DOH funding from reporting to performance, our focus is shifting as well. Our analytics team has identified a set of near-term opportunities through the balance of the measurement year ending June 30, 2017, which forecasts our gap-to-goal outcome performance opportunities. With a provider led working group of clinicians, quality, and financial personnel, we have identified key measure clusters on which we will focus in the near term, and will expand our performance focus in measurement year 3.

Desired Future State:

A healthier population, with more appropriate use of health care resources, as measured by meeting DOH identified performance goals.

An engaged partner community (providers, CBOs, hospitals, MCOs) that is focused on value based care delivery models.

An informed, educated, and empowered patient population.

Actions:

Alliance is making a Strategic investment in performance objectives. The Alliance has re-allocated $2,000,000 from operating funds and our strategic reserve to fund partners' implementation of innovative initiatives through the balance of the measurement year ending June 30, 2017 (the "Fast-Start Incentive Program") toward meeting performance gaps that had historically received insufficient attention. The incentive working group determined that the most effective interventions emphasized the role of community based providers and physicians, and de-emphasized the role of hospitals. The program will be closely monitored and adjusted to both maximize current performance, and inform to development of Alliance's Long-Term Incentive Program.

The Alliance is developing the Long-Term Incentive program focused on clusters encompassing the comprehensive set of outcome measures. Funds (DSRIP budget categories) will be re-allocated to maximize the Incentive fund, to fully emphasize the performance goals of the program. Our provider led working group of clinicians, community care organizations, quality leaders, and financial personnel will seek to increase partner engagement in the community through their vital role in the development of this Long-Term Incentive program.

Alliance has modified our leadership structure and allocation of funds to empower a focused, autonomous, agile company that will better engage with the community, implement the Incentive programs, and increase provider and patient understanding of value based care models, and how these new habits will improve health and the health care experience for all.

Specific Objectives:

Re-allocate Loss-of-Revenue budgeted funds to Incentives.

Implement Fast-Start Incentive Strategy.

Implement Long-Term Incentive Strategy.

Achieve 10% gap-to-goal performance improvement for key goals in measurement year 2

Appointment of a CEO dedicated 100% to DSRIP.

Hire a CTO to drive the critical IT infrastructure development.

Hire a full-time Medical Director to drive clinical alignment and partner engagement.

Create a new VP position focused exclusively on CBO engagement.

Create a new director position focusing on PCP engagement.

Create a new director position focusing on marketing and communication.

Add five community health workers, and four care managers.

State of New York
Department of Health
Delivery System Reform Incentive Payment (DSRIP) Program
Mid-Point Assessment Action Plan - Implementation Plan

Execute DY3 Long-Term Incentive Fund Contracts

Alliance for Better Health Care, LLC #03

Mid-Point Assessment Recommendation #1: 2.b.iii The IA recommends the PPS develop a training strategy to address the patient lack of knowledge regarding the shift to primary and preventive care away from the ED	
PPS Defined Milestones/Tasks	***Target Completion Date***
MILESTONE 1: Add marketing and communications resources to develop and implement a multimedia campaign	DY3Q1
MILESTONE 2: Hire CHWs and Care Coordinators	DY3Q1
MILESTONE 3: Hire Medical Director to educate providers	DY3Q1
MILESTONE 4: Work with Providers and Practices to promote changing their after hours phone messages to include information regarding alternatives to "dialing 911 and get to the ED"	DY3Q1
Mid-Point Assessment Recommendation #2: 2.b.iv The IA recommends the PPS develop a strategy to centralize the approach it is taking across the network to address care transitions and include behavioral health and psychosocial issues	
PPS Defined Milestones/Tasks	***Target Completion Date***
MILESTONE 1: Develop incentive strategy	DY3Q1
Task 1 - Obtain Board approval	DY3Q1
Task 2 - Develop communication plan	DY3Q1
Task 3 - Create administrative guide for providers	DY3Q1
MILESTONE 2: Support our partners to implement evidence based best practice tools	DY3Q2
Task 1 - SBAR tool will be promoted by Alliance as the standard, best practice tool for use across the Alliance network of providers.	DY3Q2
Task 2 - Gain consensus on additional tools to be implemented across the continuum	DY3Q2
Task 3 - Provide est practice patient risk assessment tool during the inpatient stay to guide the discharge process.	DY3Q2
Task 4 - Offer partners technical support to implement the selected tool(s) using Alliance Care management system	DY3Q2
MILESTONE 3: Coordinate collaboration between partner hospitals and community agencies	DY3Q1
Task 1 Hire CHWs and Care Coordinators	DY3Q1

Task 2 Analytics to identify common patients	DY3Q1
MILESTONE 4 - Offer hospitals the opportunity for Alliance to augment their existing care management resources	DY3Q2
Task 1 - Alliance to provide analytics to partner hospitals	DY3Q2
MILESTONE 5 - Implement a Care Management system and secure messaging service	DY3Q1
Task 1 - Implement messaging system using Care Connects	DY2Q4
Task 2 - Implement CrossChx Care Management system for use by Alliance Care managers and network partners as requested.	DY3Q1
Mid-Point Assessment Recommendation #3: 2.b.iv The IA recommends the PPS educate their network partners about the available models of transitions of care	
PPS Defined Milestones/Tasks	***Target Completion Date***
MILESTONE 1: Train Network partners on the multiple models of transitions of care	DY2Q4
Task 1 - Town Hall educational meeting with Dr. Amy Boutwell to train community providers	DY2Q4
Task 2 - INTERACT Training to network partners care management staff	DY2Q4
Task 3 - Educate network partners on models of transitions of care in Alliance project workgroup meetings	DY2Q4
MILESTONE 2: Participate in the NYS DOH MAX Series	DY2Q4
Task 1 - Alliance to participate in MAX series and identify network hospital to participate	DY2Q4
Task 2 - Alliance to identify staff to be trained as MAX series trainers	DY2Q4
Mid-Point Assessment Recommendation #4: 2.b.viii The IA recommends the PPS develop a strategy in conjunction with home health agencies to align the documentation in order to prevent miscommunication and missing information	
PPS Defined Milestones/Tasks	***Target Completion Date***
MILESTONE 2: Conduct INTERACT Training	DY2Q4
MILESTONE 3 - Conduct INTERACT Leadership Training	DY3Q1
Task 1 - schedule training	DY3Q1
MILESTONE 4: Provide patient education zone sheets to network partners	DY2Q4
Task 1 - Assist partners to incorporate zone sheets into their procedures for discharge planning.	DY2Q4
MILESTONE 5: Offer hospitals the opportunity for Alliance to augment their existing care management	DY3Q1
Task 1 - Alliance to provide analytics to partner hospitals	DY3Q2
MILESTONE 6: Implement a Care Management system and secure messaging service	DY3Q1
Task 1 - Implement messaging system using Care Connects	DY3Q1
Task 2 - Implement CrossChx Care Management system for use by Alliance Care managers and network	DY3Q1
Mid-Point Assessment Recommendation #5: 2.b.viii The IA recommends that the PPS workforce committee develop a strategy to recruit home health-aids	
PPS Defined Milestones/Tasks	***Target Completion Date***

MILESTONE 1: Expand number of Community Health Workers.	DY3Q2
Mid-Point Assessment Recommendation #6: 3.d.ii. Strategy to recruit certified asthma educators	
PPS Defined Milestones/Tasks	***Target Completion Date***
MILESTONE 1: Provide Asthma Educator training programs for licensed professionals for 2017	DY3Q2
MILESTONE 2: Provide Kettering AE-C Board Examination prep course for 2017	DY3Q2
Mid-Point Assessment Recommendation #7: 3.d.ii. Develop a standard curriculum for asthma home-based educators	
PPS Defined Milestones/Tasks	***Target Completion Date***
MILESTONE 1: Adopt Asthma Education for the Community Health Worker training curriculum	DY2Q4
Mid-Point Assessment Recommendation #8: 3.d.ii. Strategy to engage patient population in project	
PPS Defined Milestones/Tasks	***Target Completion Date***
MILESTONE 1: Continue working with our collaborating partners and CBO's to develop methods to identify, extract and report engaged patients from the various EHR systems in place	DY2Q4
Mid-Point Assessment Recommendation #9: Action plan addressing CBO engagment and contracting	
PPS Defined Milestones/Tasks	***Target Completion Date***
MILESTONE 1: Establish a CBO Executive Committee (CEC)	DY3Q1
MILESTONE 2: Establish regionally based CBO Collaboratives (RSC).	DY3Q1
MILESTONE 3: Execute DY3 Project Fund addendum	DY2Q4
MILESTONE 4: Execute Incentive Fund addendum	DY3Q2
MILESTONE 6: VP CBO Engagement in place	DY2Q4
Mid-Point Assessment Recommendation #10: Develop strategy to address how it will measure the effectiveness CCHL outreach	
PPS Defined Milestones/Tasks	***Target Completion Date***
MILESTONE 1: Measure effectiveness of pilot organizational assessments (organizational competence, staff awareness, patient satisfaction survey)	DY3Q2
Task 1: Conduct organizational assessments at pilot (2 FQHC) site locations	DY3Q1
Task 2: Review pilot site assessment(s) outcomes and analyze successes/gaps and use results to drive training plan	DY3Q1
Task 3: Assist pilot sites in developing comprehensive training plan that address gaps	DY3Q1
Task 4: Initiate pilot sites CCHL training plan	DY3Q1
Task 5: Develop method to evaluate and modify training plan as needed	DY3Q1
Task 6: Identify 2 additional sites for strategy roll out	DY3Q1

Task 7: Replicate best practices from first wave of pilot sites to the 2 additional pilot sites for strategy roll out	DY3Q2
MILESTONE 2: Assess ability to measure impact of patient-centered outcomes by implementing a comprehensive CCHL training strategy	DY3Q2
Task 1: Develop plan that will outline timeframe of baseline member utilization data to be used in the measure and determines timeframe to begin reviewing data once training strategy is implemented	DY3Q2
Task 2: Plan the research and Identify a framework, generate hypothesis, and determine study population and research design	DY3Q2
Task 3: Begin to collect data to measure impact of CCHL training on identified population, and plan to conduct full study in 2018 and annually thereafter	DY3Q2
Mid-Point Assessment Recommendation #11: Develop a strategy to better address the CCHL training needs of its partners	
PPS Defined Milestones/Tasks	***Target Completion Date***
MILESTONE 1: Review of outcomes of cultural competency organizational assessments	DY2Q4
Task 1:Evaluate results of the assessments, identify training needs and develop training plans	DY2Q4
MILESTONE 2: Engage Community Health Workers (CHWs) in hot spot locations	DY3Q1
Task 1: Hire and train CHW supervisor and 4 CHWs and deploy to hot spots areas.	DY3Q2
MILESTONE 3: Collaborate with Workforce to distribute and analyze cultural competency/health literacy training needs survey to contracted partners that were not part of the pilot program	DY3Q1
Task 1: Develop survey questions	DY3Q1
Task 2: Distribute survey through Survey Monkey	DY3Q1
Task 3: Analyze survey results (CCHL taskforce to assist)	DY3Q1
Task 6: Collaborate with Workforce to develop a plan that outlines ongoing CCHL training	DY3Q1
Mid-Point Assessment Recommendation #12: The IA recommends that the PPS develop metrics to assess its most effective strategies to engage Medicaid members and the uninsured.	
PPS Defined Milestones/Tasks	***Target Completion Date***
MILESTONE 1: Achieve 10% year over year improvement in PAM scores demonstrated by Flourish data	DY2Q4
MILESTONE 2: Achieve 10% year over year decrease ER visits of uninsured demonstrated by DOH findings	DY2Q4
MILESTONE 3: Achieve 10% year over year increase preventive; primary care; and behavior health care access	DY2Q4
MILESTONE 4: Achieve 10% year over year reduction in hospital readmissions demonstrated by claims data	DY2Q4
Mid-Point Assessment Recommendation #13: The IA requires the PPS to assess the status of its network partner's involvement in VBP	
PPS Defined Milestones/Tasks	***Target Completion Date***
MILESTONE 1: Develop a Value Based Payments Needs Assessment ("VNA")	DY3Q2
MILESTONE 1: Administer Value Based Payments Needs Assessment ("VNA")	DY3Q2

Mid-Point Assessment Recommendation #14: The IA requires that the PPS establish a plan to further educate and support their partners move towards VBP arrangements	
PPS Defined Milestones/Tasks	***Target Completion Date***
MILESTONE 1: Develop VBP educational curriculum	DY2Q4
MILESTONE 2: Conduct VBP educational sessions with all Member organizations	DY3Q2
MILESTONE 3: Conduct VBP educational sessions with all Manager organizations	DY3Q2
MILESTONE 4: Roll out Incentive strategy to partners	DY3Q2
MILESTONE 6: Develop VBP primer and release on-line to all partners	DY3Q2
Mid-Point Assessment Recommendation #15: Develop partner engagment action plan	
PPS Defined Milestones/Tasks	***Target Completion Date***
MILESTONE 1: Hire CMO	DY2Q4
MILESTONE 2: Create VP Community Engagment position	DY2Q4
MILESTONE 3: Create Director PCP Engagement position	DY2Q4
Mid-Point Assessment Recommendation #16:	
PPS Defined Milestones/Tasks	***Target Completion Date***
MILESTONE 1: Extend Project Fund addendums through DY3	DY2Q4
MILESTONE 3: Develop and implement Incentive program	DY3Q2
Mid-Point Assessment Recommendation #17: Overall strategic organizational approach	
PPS Defined Milestones/Tasks	***Target Completion Date***
MILESTONE 1: Project Fund methodology for DY3-4 approved by Board	DY2Q4
MILESTONE 2: Short Term Incentive methodology approved by Board	DY2Q4
MILESTONE 3: Long Term Incentive methodology approved by Board	DY3Q1
MILESTONE 4: Put new leadership resources in place	DY2Q4
Task 1: CEO	DY2Q4
Task 3: CMO	DY2Q4
Task 4: CIO	DY2Q4
Task 5: VP PMO	DY2Q4

State of New York
Department of Health
Delivery System Reform Incentive Payment (DSRIP) Program
Mid-Point Assessment Action Plan - Partner Engagement

		Partner Engagement											
Partner Category		***2.a.i.***	***2.b.iii.***	***2.b.iv.***	***2.b.viii***	***2.d.i.***	***3.a.i.***	***3.a.iv.***	***3.d.ii.***	***3.g.i.***	***4.a.iii.***	***4.b.i.***	
Practitioner - Primary Care				480			190	455					
Practitioner - Non-Primary Care				299				267					
Hospital - Inpatient/ED				6	6			6					
Hospital - Ambulatory													
Clinic													
Mental Health							24	67					
Substance Abuse								17					
Case Management													
Health Home													
Community Based Organization (Tier 1)			2	2		7	1	1	3		6	1	
Nursing Home													
Pharmacy													
Hospice													
Home Care					5								
Community Based Organization (Tier 2)			2	2	3	2	1	1		1	2	1	
Community Based Organization (Tier 3)			6	5	1	4	9	3		5	5	1	
Other (PAM Provider)						300							

State of New York
Department of Health
Delivery System Reform Incentive Payment (DSRIP) Program
Mid-Point Assessment Action Plan - Funds Flow

Alliance for Better Health Care PPS # 03		Funds Flow (all funds)			
Partner Category		***MAPP Funds Flow through DY2, Q3***	***Projected Funds Flow through DY2***	***% of Earned Dollars Planned for Distribution DY3***	***% of Earned Dollars Planned for Distribution DY4 DY5***
Practitioner - Primary Care		$ 2,596,288	$ 880,918	15%	15%
Practitioner - Non-Primary Care		$ -	$ -		
Hospital - Inpatient/ED		$ 4,414,795	$ 2,755,498	10%	10%
Hospital - Ambulatory		$ 1,734,120	$ -	5%	5%
Clinic		$ 4,545,269	$ 1,119,265	14%	14%
Mental Health		$ 930,153	$ 595,998	3%	3%
Substance Abuse		$ 1,401,923	$ 531,760	3%	3%
Case Management		$ -	$ -	3%	3%
Health Home		$ 450,000	$ -	1%	1%
Community Based Organization (Tier 1)		$ 380,309	$ 188,135	8%	8%
Nursing Home		$ -	$ -		
Pharmacy		$ -	$ 16,128		
Hospice		$ 78,502	$ 14,251		
Home Care		$ 1,977,141	$ 1,887,779	14%	14%
Community Based Organization (Tier 2)		$ 276,438	$ 361,508	8%	8%
Community Based Organization (Tier 3)		$ 690,768	$ 396,868	8%	8%
		$ -	$ -		
PMO		$ 3,865,891		8%	8%
Total		$ 23,341,597	$ 8,748,108		