Mid-Point Assessment Recommendation:

AMCH PPS Recommendation 1

2.a.i.: Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management: The IA recommends that the PPS develop a corrective action plan to successfully complete the project requirements that the IA determined were not completed by the PPS Speed & Scale commitment date for this project. The PPS must provide a revised timeline for the completion of the six project requirements that were not completed by DY2, Q2 as part of this action plan.

PPS Action Plan Narrative:

Since the Midpoint Assessment, the PMO believes significant progress has been made towards integrating our complex regional health care system. All contracted organizations are actively participating in 2ai, ensuring that partners are engaged in the transformation effort. Phase II Contracts, covering the next 15 months, have been developed with a focus on project-specific engagement, connectivity and outcome measures. These contracts have been executed with a wide variety of provider types (PCP, Non-PCP, Hospital, Clinic, Care Management, Health Home, Nursing Home, CBO and Mental Health) who comprise the PPS's integrated network and provide care to the vast majority of our attributed patient population. While the PPS has faced challenges, including an aggressive speed and scale timeline matched with the absence of capital funding to promote advanced technology and innovation, the PMO is confident that continued, innovative collaboration within the participating provider network will help to alleviate said challenges. Due to the lack of capital funding and an outstanding response to a second request for capital funding in response to RFA# 1607010255, Statewide Health Care Facility Transformation Program, the PPS has refocused efforts into developing a less expensive short-term IT solution utilizing MAPP, Salient, RHIO/SHIN-NY (Hixny), PSYCKES, a PPS analytics platform and a centralized Care Management Solution. Due to the urgent need to address both Analytics and Care Coordination needs, the PMO has chosen to contract with a renowned DSRIP vendor as well as Care Management Providers through the New York State Health Home Program.

The following narrative will address the corrective action plans created for Project 2.a.i, Milestones 1, 3, 4, 5, 7 and 9. In addition, AMCH PPS Integrated Delivery System Model is being submitted (Attachment A).

AMCH PPS has a strong commitment to engage partners across all provider types. Participating providers continue to strive toward Milestone completion through their ongoing and valued committee work, PCP Advisory Group, and contract deliverables. Phase I Contracting had several metrics in regards to engagement and active participation within project subcommittees and work-stream committees. These included, but were not limited to, clinical participation on the Behavioral Health project sub-committees, an E.H.R. subcommittee comprised of both clinical experts and IT representation, and a Clinical and Quality Affairs Committee that meets monthly to bring all project-related subcommittee representatives together including Asthma, Cardiovascular Disease , Behavioral Health, Health Home At Risk Intervention, and ED Care Triage. Additionally, community participation and representation on subcommittees and committees is vital for project success; the AMCH PPS understands and encourages the need for continued engagement. The AMCH PPS's contracted partnering organizations serve the majority of the attributed patient population. The contracts are outlined with very specific metrics that directly impact project participation, milestone completion, and outcome measures. Although the

contracted partners do not add up to the total number of providers across all provider types that were committed to the speed and scale commitment set in January of 2015, the providers that are contracted make up the majority of the providers located within our five- county catchment area and thus, have a direct impact on all Medicaid attributed lives. The non-contracted partners that make up the difference in our speed and scale commitments predominately fall outside of the five counties and are actively participating in their local PPSs. These providers are still engaging Medicaid patients across NYS but are focused on projects in counties such as Ulster or Duchess County where our counterparts, Montefiore and Westchester PPS, are more actively engaged. It is important to note that during the very early stages of the formation of the provider network, the AMCH PPS committed to serving a geographic region of nine counties and as such were building an inclusive network with providers from Schenectady, Rensselaer, Ulster and Dutchess Counties. However, after the formalities of the attribution threshold logic were introduced, the AMCH PPS was advised to scale down the focused catchment area to its current five counties. This change continues to affect the provider network and the feasibility of reaching speed and scale commitments. Though these challenges are evident, the AMCH PPS collaborates with overlapping and nearby PPSs to align projects, ensure de-duplication of actively engaged patients, and streamline the roll-out of project initiatives to help minimize efforts of participating providers. This alignment allows us to reach all attributed lives with policy and systematic changes as a means to improve the quality of care provided. As DOH threshold logic was established late in the application phase, it would greatly benefit the AMCH PPS if the State and IA would consider a modification to the commitment numbers reflected in the previous commitments made in January of 2015. A modification will include participating providers in our five county region. A practitioner engagement template is submitted for your reference. In addition, the patient engagement commitments, as outlined in the DOH application, are set to ramp up from 0-100 over time. New guidance was provided during DY2Q2 remediation stating that patient engagement resets at 0 each year. This contradicts all guidance in commitment levels and the AMCH PPS is concerned that we will not be able to engage the total number of patients that we have projected and we therefore seek clarification on the documentation change.

The AMCH PPS Integrated Delivery System diagram (Attachment A) illustrates how the Clinical, Mental Health and Care Management providers share information with Hixny and subscribe to ADT alerts and event notifications. These event notifications ensure PCPs and Health Home Care Managers are aware of their patient's hospitalizations and emergency room encounters and have access to the patient's complete community health record via Hixny. In addition, many of the Health Home Care Managers and Mental Health providers utilize PSYCKES, a secure, HIPAA-compliant web-based platform for sharing Medicaid claims, encounter data and other state administrative data. The system is designed to support clinical decision-making and quality improvement. 65% of our attributed population has PSYCKES indicators in MAPP; as such, the AMCH PPS is highly considering implementing the tool in both the three hospitals and our PPS's Centralized Care Management Program. This integration model (Attachment A) will be fully operationalized by 9/30/17.

The IDS Connectivity updated plan focuses on three steps illustrated in Attachment B. The first step: *Partner System Integration via Hixny:* Although all of our safety-net PCPs have established connectivity to Hixny and subscribed to hospital and emergency room admission, discharge and transfer alerts, we are still working with some of our behavioral health and nursing home providers who have signed QE agreements to establish connectivity. Our PPS has a close working relationship with Hixny and we continue to facilitate connectivity for partners by informing them of EHR connectivity incentive programs (DEIP), and work with vendors who have not established Hixny connectivity in the past. The

second step: *Establish Hixny Bi-directional Connectivity for Partners:* 2.a.i partners have two contract metrics associated with demonstrating clinical data submission and subscription to event notifications. The PMO is requiring partners to comply with the RHIO Data Contribution Specifications required for the DEIP program (Attachment C) as well as demonstrate they have processes in place to address Hixny event notifications. The third step: *EHR Structured Element Configuration:* The PPS has created an EHR Subcommittee operating under the direction of the Technology and Data Management Committee to provide support to partner EHR analysts tasked with creating the structured elements in the data roadmaps developed and approved by our Clinical Subcommittees. Project specific Phase II contract metrics will track the completion of these EHR enhancements.

With all of the above steps in place the AMCH PPS will have a fully implemented Integrated Delivery System capable of tracking the care of our attributed patients throughout the continuum of care with a focus of enhancing care coordination for at risk patients with a goal to decrease avoidable Emergency Room Visits, Readmissions and Hospitalizations.

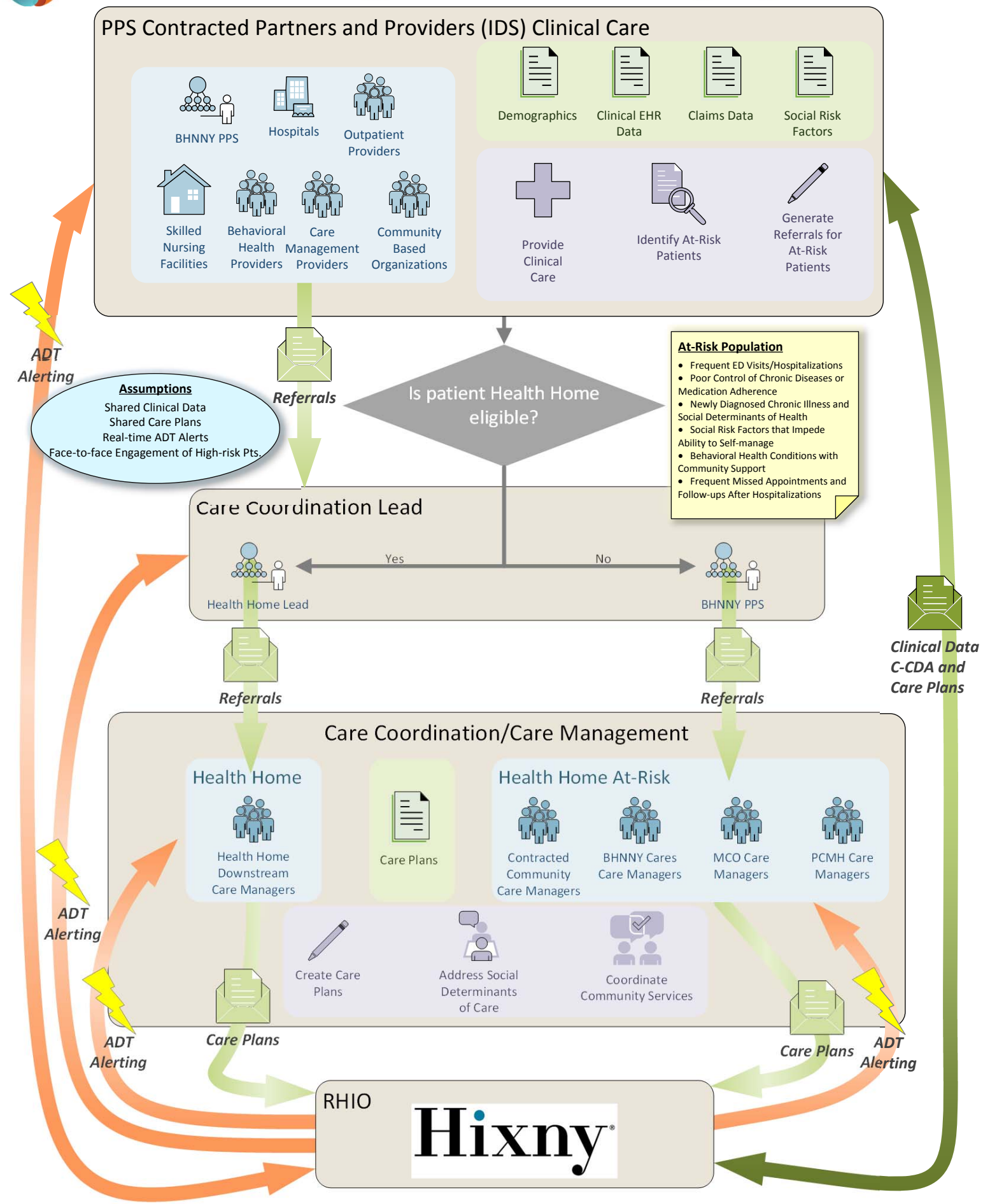
The PPS maintains a close relationship with Hixny and we collaboratively work with both existing and newly contracted partners to establish bi-directional connectivity. Additionally, the PPS has created Phase II contract metrics to ensure that QE agreements and DSRIP Performing Provider System Hixny One-to-One Exchange Authorization Forms are executed for all partners and that the partners are contributing and utilizing data available via Hixny. The PPS will continue to monitor this process and align with the SHIN-NY RHIO connectivity requirements being developed pursuant to SHIN-NY Regulation - 10 NYCRR Part 300 which requires participation of regulated healthcare facilities: General hospitals- March 9, 2017, and the remaining regulated facilities by March 9, 2018.

Additionally, the AMCH PPS has made significant progress towards achieving NCQA Level 3 PCMH and/or APC recognition. In an effort to assist our contracted primary care partners toward recognition, the Health Care Association of New York State (HANYS) has been chosen as the vendor to support the PPS in its PCMH transformation efforts. In December 2016, HANYS was awarded a technical assistance contract with New York State to partner with primary care practices across the state and guide them through the transformation to Advanced Primary Care (APC). This dual designation will further strengthen transformation efforts on behalf of the PPS. HANYS is currently in the process of working with our contracted partners to determine if PCMH versus APC is the most appropriate path for their organization to take. If our partners choose to obtain PCMH recognition, the PPS has allocated the funding support into two distinct trajectories called Tier I and Tier II. In Tier I, The AMCH PPS PMO will provide an opportunity for each of the contracted partnering organizations to choose one site within their organization, with the highest Medicaid lives, that would benefit from participating in one to one training. In total, there will be potentially nine practice sites that will need one to one training. These chosen practice sites would then work within their organizations to spread the information learned through HANYS to assist other practice sites toward achievement. In Tier II, the PPS is providing all 11 organizations an opportunity to participate in the group training/learning collaboratives which may include up to 78 participating primary care sites in total. To meet the initiatives outlined in the implementation plan, we structured the HANYS engagement to encompass a thorough current state assessment, gap analysis based on the assessment to identify risks in order to close the gaps during engagement, one on one learning sessions as well as group learning collaboratives, train the trainer approach, and a robust sustainability plan to assure the maintenance of PCMH or APC recognition post

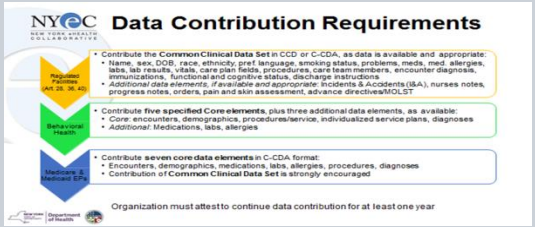
HANYS engagement. The PPS has also aligned Phase II funding metrics with PCMH must-pass elements and critical factors as another strategy to track, monitor, and assure maintenance of recognition. The PPS has also continued the Primary Care Advisory Group as a subcommittee to support the primary care providers through transformation efforts as well as provide networking opportunities and a forum to allow for brainstorming of workflows to assist with transformation.

The Integrated Delivery System is the most important project of all and the AMCH PPS takes this notion very seriously. The full implementation of all projects to include system change, policy change, and culture change, will ultimately create an Integrated Delivery System to benefit the population in its entirety. Though challenges exist and the change ahead is not easy, the AMCH PPS remains very much committed to fully implementing this project as well as the remaining projects with the goal of significantly impacting outcome measures while reducing avoidable ED visits and unnecessary readmission rates.

BetterHealth for Northeast New York Integrated Delivery System



IDS Connectivity Corrective Action Plan 9/30/2017

• Step One: Partner System Integration	• Step Two: Partner Bi-directional Connectivity Established	• Step Three: Partner Structured Element EHR Configuration
• Hixny QE Agreement and One-To-One Exchange Agreement will be signed and connectivity will be established with Hixny (RHIO) that meets minimum requirements as defined by AMCH PPS (Phase 2 Contract Hurdle Metric) • Safety Net - PCPs, Non-PCPs, Hospitals, Mental Health Providers (SUD/BH), Nursing Homes, Care Managers	• Partners contribute data to Hixny as defined by NYeC:  • Partners subscribe to ADT Alerts and event notifications	• Partners configure their EHRs with Project-Specific structured data elements in support of the clinical projects: Asthma, CVD, Behavioral Health, Health Home at Risk. These activities are being coordinated thorough the EHR Subcommittee and are required in the Phase 2 Contracts

AMCH PPS Analytics Platform for performance reporting, risk stratification and predictive analytics

Data Contribution Requirements

Regulated Facilities (Art. 28, 36, 40)

- Contribute the **Common Clinical Data Set** in CCD or C-CDA, as data is available and appropriate:
  - Name, sex, DOB, race, ethnicity, pref. language, smoking status, problems, meds, med. allergies, labs, lab results, vitals, care plan fields, procedures, care team members, encounter diagnosis, immunizations, functional and cognitive status, discharge instructions
  - *Additional data elements, if available and appropriate*: Incidents & Accidents (I&A), nurses notes, progress notes, orders, pain and skin assessment, advance directives/MOLST

Behavioral Health

- Contribute **five specified Core elements**, plus three additional data elements, as available:
  - *Core*: encounters, demographics, procedures/service, individualized service plans, diagnoses
  - *Additional*: Medications, labs, allergies

Medicare & Medicaid EPs

- Contribute **seven core data elements** in C-CDA format:
  - Encounters, demographics, medications, labs, allergies, procedures, diagnoses
  - Contribution of **Common Clinical Data Set** is strongly encouraged

Organization must attest to continue data contribution for at least one year

Mid-Point Assessment Recommendation:

AMCH PPS Recommendation 2- 2biii:

The IA recommends that the PPS develop a corrective action plan to successfully complete the project requirements that the IA determined were not completed by the PPS Speed & Scale commitment date for this project. The PPS must provide a revised timeline for the completion of the project requirement that was not completed by DY2, Q2 as part of this action plan.

PPS Action Plan Narrative:

AMCH PPS is identifying additional meaningful tasks to support the overall project objective of developing an evidence-based care coordination and transitional care program that will assist patients to link with a primary care physician/practitioner, support patient confidence in understanding and self-management of personal health condition(s), improve provider to provider communication, and provide supportive assistance to transitioning members to the least restrictive environment. While the PPS has faced challenges, including an aggressive speed and scale timeline matched with the absence of capital funding to promote advanced technology and innovation, the PMO is confident that continued, innovative collaboration within the participating provider network will help to alleviate said challenges. The risk score of this project was assessed as a 3, indicating the project could meet intended goals but requires some performance improvements and overcoming challenges. The met three out of four project requirements by the committed implementation date. We have used experiences from missed and completed milestones to strengthen the approach outlined by our action plan. The PPS has taken steps such that the action plan will be effective and meaningful to the project, and support the achievement of overall project objective of assisting patients with access to primary care services while supporting their self-management abilities.

The corrective action plan put in place to address milestones not completed by 9/30/2016 includes several components: refining/identifying additional tasks and timelines, while continuing to build on success that was attained through DY2Q2.

Milestone 2: Participating EDs will establish partnerships with community primary care providers with an emphasis on those who are PCMHs and have open access scheduling.

- *Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3.*
- *Develop process and procedures to establish connectivity between the emergency department and community primary care providers.*
- *Ensure real time notification to a Health Home care manager as applicable.*

NCQA PCMH / NYS APC Model: The AMCH PPS has made significant progress in achievement toward NCQA Level 3 PCMH and/or APC recognition as exhibited by Columbia Memorial Hospital now having 12 out of 15 sites 2014 Level 3 recognized. In an effort to assist our contracted primary care partners toward recognition, the Health Care Association of New York State (HANYS) has been chosen as the vendor to support the PPS in its PCMH transformation efforts. Additionally, in December 2016, HANYS was awarded a technical assistance contract with New York State to partner with primary care practices across the state and guide them through the transformation to Advanced Primary Care (APC). This dual designation will further strengthen transformation efforts on behalf of the PPS. HANYS is currently in

process of working with our contracted partners to determine if PCMH versus APC is the most appropriate path for their organization to take. For our partners who choose to obtain PCMH recognition, the PPS has allocated the funding support into two distinct trajectories called **Tier I and Tier II.** In Tier I, The AMCH PPS PMO will provide an opportunity for each of the contracted partnering organizations to choose one site within their organizations, with the highest Medicaid lives, that would benefit from participating in one to one training. In total, there will potentially be 9 practice sites that will need one to one training. These chosen practice sites would then work within their organizations to spread the information learned through HANYS to assist other practice sites toward achievement. In Tier II, the PPS is providing all 11 organizations an opportunity to participate in the group training/learning collaboratives. This could be up to 78 participating primary care sites in total. To meet the initiatives outlined in the implementation plan, we structured the HANYS engagement to encompass a thorough current state assessment, gap analysis based on the assessment to identify risks in order to close the gaps during engagement, one on one learning sessions as well as group learning collaboratives, train the trainer approach, and a robust sustainability plan to assure the maintenance of PCMH or APC recognition post HANYS engagement.
The PPS has also aligned Phase II funding metrics with the PCMH "must-pass" elements and critical factors as another strategy to track, monitor, and assure maintenance of recognition. The PPS has also continued the Primary Care Advisory Group as a subcommittee to support the primary care providers through transformation efforts as well as provide networking opportunities and a forum to allow for brainstorming of workflows to assist with transformation. During this process our partners are also working on achieving this recognition to upgrade and/or achieve new recognition. The AMCH PPS has improved the percent of practices that are PCMH certified since the midpoint assessment. The current complement of PCMH practices has gone from 20% of our network PCPs to approximately 44.6% of contracted primary care partners within the CVD project. There are approximately 29.7% with 2011 recognition and 15.0% with 2014 recognition.

<u>Primary care and ED connectivity:</u>

To understand and address region specific issues impacting collaboration between EDs and primary care practices, beginning in November 2016, the participating hospitals began hosting regional meetings with staff from the Emergency Department, hospital, primary care practices, and behavioral health organizations. These meetings were intended to assist us in determining regional best practices, priorities and challenges while identifying steps to foster communication between the ED and PCP to reduce the barriers patients experience when transitioning between these two locations. These meetings will continue to be held on a rotating basis.

AMCH PMO is working with hospitals and PCPs to ensure patients receive the appropriate transition of care. In September 2016 the ED Care Triage sub-committee approved an ED process flow that included patient triage, referral, review and assessment. Hospitals are working on implementing this process flow while adding patient navigator services in the ED. EDs are also developing protocols to provide discharge summaries to providers that will be responsible for follow up care within 48-72 hours of discharge and patient navigators will track whether providers have been notified of a patient's discharge and need for follow-up care. On the PCP side, participating practices will designate staff to serve as contacts for the ED patient navigators for access and care coordination needs. This process will facilitate and improve

provider-to-provider communication and strengthen care transitions. The patient navigator assures the patients are receiving the necessary follow-up appointments needed in the appropriate time frame.

To assist the referral process in the ED, ensure patients are receiving the necessary wrap around care needed to address social determinants of health and eliminate barriers preventing them from self-managing their health, the AMCH PPS is working aggressively with care management partners, PCP offices, and hospitals to implement a centralized care coordination system to be operated by the PMO. Providers and community organizations are able to refer a patient to BHNNY Cares, AMCH PPS's care coordination care management initiative, and the BHNNY Cares staff will determine attribution and then either provide appropriate short-term care coordination services or refer patients to the Health Home care management agencies for additional services as appropriate. This simplifies the referral process for providers, facilitates referrals to Health Homes and initiates care coordination services for at-risk patients.

(This section may need revision following feedback from Dr. Robinson) AMC Hospital has plans for the development of a Transitional Care Clinic which would process discharged patients through a clinic staffed by Advanced Primary care practitioners (NP, PA). This model (re)directs discharged patients through a transitional pathway in the interim of hospital and PCP visit within the time frame instructed by the hospital or ED discharge.

Encounter Notification Service (ENS) is installed in all PCP offices and EDs:

IN 2016, as part of the Clinical Integration strategy, we performed a current state assessment, defined future state, and completed a gap analysis between current state and future state on the interconnected systems' ability to send, receive and use alerts and secure messages to facilitate timely care coordination and management. As we continue with our efforts to strengthen the connectivity between EDs and primary care practices, we will update the current state assessment of contracted partners in the interconnected systems' ability to send, receive, and use alerts and secure messages. Following the updated analysis, we will work closely with partners who are in need of additional connectivity to address the gaps utilizing Hixny (RHIO) and SHIN-NY processes to support the use of ADT alerts across the PPS. Existing protocols will be updated and, if necessary, new protocols to be developed to follow upon receipt of Hixny-generated alerts/and hospital discharge summaries.

AMCH PPS will track progress through contract metrics created through collaboration with a multi-disciplinary team, including clinical leads from across the PPS. These contract metrics will directly impact deliverables and are aligned with the 2.b.iii objectives and implementation plan. Many metrics are defined as bundle or prerequisite metrics, to ensure successful completion of all tasks that are necessary in order to effectively implement the project. The PPS will also utilize a data analytics tool that will leverage data sources such as MAPP to provide analytics specific to our PPS and projects. Additionally, we will continue to monitor, in collaboration with Hixny and our partners, overall progress on the ability to share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look-up, and support timely care management decisions.

Mid-Point Assessment Recommendation:

AMCH PPS Recommendation 3: 3.b.i:

The IA recommends that the PPS develop a corrective action plan to successfully complete the project requirements that the IA determined were not completed by the PPS Speed & Scale commitment date for this project. The PPS must provide a revised timeline for the completion of the 13 project requirements that were not completed by DY2, Q2 as part of this action plan.

PPS Action Plan Narrative:

AMCH PPS is identifying additional meaningful tasks to achieve the overall project objective of supporting the implementation of evidence-based best practices for disease management in medical practice for adults with cardiovascular conditions. While the PPS has faced challenges, including an aggressive speed and scale timeline matched with the absence of capital funding to promote advanced technology and innovation, the PMO is confident that continued, innovative collaboration within the participating provider network will help to alleviate said challenges. Unofficial feedback on the appeals that was provided to facilitate our MPA response indicated that the PPS met 9 out of the 20 project requirements by the committed implementation date. We have used experiences from missed and completed milestones to strengthen the approach outlined by our action plan. The PPS has taken steps such that the action plan will be effective and meaningful to the project, and support the implementation of strategies as outlined in the **Million Hearts Action Guides** for controlling hypertension and for identifying and treating patients who use tobacco.

The corrective action plan put in place to address milestones not completed by 9/30/2016 includes several components: refining/identifying additional tasks and timelines, focusing on and continuing to improve patient and provider engagement numbers, and continuing to build on success that was attained through DY2Q2. For example, while milestone 8 ("walk-in BP screening") was completed, there will be ongoing incentives for participating practices to continue to offer the service in order to improve access for primary care services for patients with hypertension.

The narrative has been structured to align with The **Million Hearts Hypertension Control Change Package for Clinicians** (HCCP), https://millionhearts.hhs.gov/files/HTN_Change_Package.pdf. The HCCP groups key process improvements in ambulatory setting into three broad focus areas; **Key Foundations, Population Health Management, and Individual Patient Support.** With the intent of aligning the narratives to Million Hearts strategies, the 11 missed milestones are distributed across the three groups as follows.

Million Hearts Focus Areas	AMCH PPS Missed Milestones
Key Foundations:	• RHIO/SHIN-NY connectivity (M2) • PCMH/APC recognition (M3) • Correct BP measurement techniques (M9) • Home BP monitoring (M14) • Adoption of Million Hearts Campaign strategies (M18) • Primary care provider engagement (M20)
Population Health Management	• Identify patients with repeated high BP without a diagnosis of HTN (M10) • Generate lists of HTN patients with no recent visit (M15)
Individual Patient	• EHR prompts to complete 5A's of tobacco control (M5)

Support	• Prescribe once-daily or fixed-dose combination pill regimens (M11) • Facilitate referrals to NYS Smoker's Quit Line (M16)

Key Foundations:

RHIO/SHIN-NY connectivity (M2): The PPS maintains a close relationship with HIXNY and we have worked collaboratively with both existing and newly contracted partners to establish bi-directional connectivity. Additionally, the PPS has created Phase II contract metrics to ensure that not only are the QE agreements and DSRIP Performing Provider System HIXNY One-to-One Exchange Authorization Forms are executed for all partners, but that the partners are contributing and utilizing data available via HIXNY. The PPS will continue to monitor this process and align with the SHIN-NY RHIO connectivity requirements being developed pursuant to SHIN-NY Regulation - 10 NYCRR Part 300 that requires participation of regulated healthcare facilities: General hospitals- March 9, 2017, Rest of regulated facilities by March 9, 2018.

PCMH/APC recognition (M3): The AMCH PPS has made significant progress in achievement toward NCQA Level 3 PCMH and/or APC recognition. For example, Columbia Memorial Hospital has had 12 out of 15 practices recognized under 2014 Level 3 standards. In an effort to assist our contracted primary care partners toward recognition, the Health Care Association of New York State (HANYS) has been chosen as the vendor to support the PPS in its PCMH transformation efforts. Additionally, in December 2016, HANYS was awarded a technical assistance contract with New York State to partner with primary care practices across the state and guide them through the transformation to Advanced Primary Care (APC). This dual designation will further strengthen transformation efforts on behalf of the PPS. HANYS is currently in process of working with our contracted partners to determine if PCMH versus APC is the most appropriate path for their organization to take. For our partners who choose to obtain PCMH recognition, the PPS has allocated the funding support into two distinct trajectories called **Tier I and Tier II.** In Tier I, The AMCH PPS PMO will provide an opportunity for each of the contracted partnering organizations to choose one site within their organizations, with the highest Medicaid lives, that would benefit from participating in one to one training. In total, there will potentially be 9 practice sites that will need one to one training. These chosen practice sites would then work within their organizations to spread the information learned through HANYS to assist other practice sites toward achievement. In Tier II, the PPS is providing all 11 organizations an opportunity to participate in the group training/learning collaboratives. This could be up to 78 participating primary care sites in total. To meet the initiatives outlined in the implementation plan, we structured the HANYS engagement to encompass a thorough current state assessment, gap analysis based on the assessment to identify risks in order to close the gaps during engagement, one on one learning sessions as well as group learning collaboratives, train the trainer approach, and a robust sustainability plan to assure the maintenance of PCMH or APC recognition post HANYS engagement.
The PPS has also aligned Phase II funding metrics with PCMH must pass elements and critical factors as another strategy to track, monitor, and assure maintenance of recognition. The PPS has also continued the Primary Care Advisory Group as a subcommittee to support the primary care providers through transformation efforts as well as provide networking opportunities and a forum to allow for

brainstorming of workflows to assist with transformation. During this process our partners are also working on achieving this recognition to upgrade and/or achieve new recognition. The current complement of PCMH practices has gone from 20% of our network PCPs to approximately 44.6% of contracted primary care partners within the CVD project. There are approximately 29.7% with 2011 recognition and 15.0% with 2014 recognition.

Correct BP measurement techniques (M9): Accurate blood pressure management is a critical component to hypertension management in our patient populations. The PMO recently developed a blood pressure competency tool using national evidence based guidelines JNC 8 as well as of **Million Hearts Measure Up Pressure Down** (Plank 1 Tool 11 Blood Pressure Accuracy and Variability Quick Reference) which was formally approved by the CVD subcommittee and CQAC. The expectation is that our contracted primary care partners will complete necessary competencies with applicable clinical staff yearly as well as incorporate this competency assessment into new employee orientation. As part of ongoing monitoring of implementation activities, phase II funds have been aligned to support this measure and ensure its completion. As part of funds flow documentation, contracted primary care partners are required to submit evidence of protocols and training documentation of the assessment tool in both June 2017 and March 2018 submissions.

Home BP monitoring (M14): The PPS is also currently strategizing a home blood pressure monitoring program. Koinonia Primary Care, Albany Family Medicine at Community Care and Columbia Memorial Hospital practices have voiced interest and agreed to be pilot sites for the initiative. Preliminary conversations regarding the program included the type and amount of blood pressure cuffs needed for a successful pilot, as well as review and approval of the tools and protocols from **the AMA / Johns Hopkins program, "Self-measured blood pressure monitoring program: Engaging patients in self-measurement"** for the implementation of home blood pressure monitoring with follow-up support for appropriate patients identified by clinicians across the participating practitioner organizations. We are also identifying funding for the purchase of equipment to support the primary care practices. Additionally, the Albany County Department of Health has been designated by **Target BP Initiative** through the American Heart Association to assist with implementation of Million Hearts. The Target BP Initiative complements Million Hearts and follows a MAP framework (Measure accurately; Act rapidly; Partner with patients, families, and communities to promote self-management). This framework aligns with many key components of the CVD project requirements; therefore we will be working collaboratively with Albany County Health Department as part of the project requirement to ensure its success.

Adoption of Million Hearts Campaign strategies (M18): As an overall strategy to the implementation of the CVD project, the Million Hearts Campaign framework has been adopted and implemented by the AMCH PPS. The CVD subcommittee as well as CQAC, has reviewed, adopted, and begun efforts to implement the Hypertension Change packet from the Million Hears Campaign as well as the JNC 8 national evidence based guidelines to support management of hypertension and the clinical algorithm to support medication management. Additionally, the CVD subcommittee has also reviewed, approved and begun implementation efforts on “2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults for the treatment of Cholesterol Management.” At the March 2017 Primary Care Advisory Group meeting as well as CQAC, the PMO will share the

"Treating Tobacco Dependence Practice Manual" developed by American Academy of Family Physicians as well as the Million Hearts Action Guide, “Identifying and Treating Patients Who Use Tobacco” to guide practices with smoking cessation efforts.

Primary care provider engagement (M20): The AMCH PPS has actively engaged well over 80% of its contracted primary care providers, in this project. Providers are engaged in monthly project subcommittee meetings where processes are developed, protocols are distributed, and best practices are shared. These providers proactively share what works well within their own organization and are eager to share with others. Although the project does not consist of 80% of providers in our network, the project has 320 primary care providers engaged and actively participating, 1187 non-PCPs, 8 clinics, 8 Case Management providers, 66 Mental Health providers, 1 substance abuse provider, and 3 pharmacies. Of the 1593 providers engaged in this project, 117 are safety net providers. Our network has had some transition of providers since it was created in November 2014 and therefore primary care providers that were actively practicing at organizations are no longer there, hence giving a false number of “unengaged” providers left in the network. We will continue to resolve this issue as the network opens to remove retired providers.

Population Health Management:

Identify patients with repeated high BP without a diagnosis of HTN (M10) & Generate lists of HTN patients with no recent visit (M15):

In an effort to create PPS wide systems to assist clinicians in their efforts to control Hypertension, the PPS has done a great deal of work on key components of the project as a step toward completion. The PPS has made considerable progress since the September submission in the development and implementation of an IT roadmap for the CVD project working collaboratively with the EHR subcommittee. This approved roadmap was then presented by the partners’ IT representatives at the January and February EHR Subcommittee Meetings. Contracted partners with various EHRs, i.e., Allscripts Touchworks. EclinicalWorks and Medent have recently submitted and presented their current, near and far term strategies to create all of the required CVD data elements in their EHRs at subcommittee meetings.

Utilizing the PPS’ EHR Roadmap for the CVD project as described above, partners will be able to develop processes to create registries and develop the clinical decision support in the EHRs necessary to identify patients with elevated blood pressures without a diagnosis of hypertension and schedule them for visits as well as to identify patients with hypertension that have not had a recent visit and bring them into care. Assisting contracted partners to develop these registry tools will further strengthen their care management/care coordination efforts for patients with Hypertension. As part of ongoing monitoring of implementation activities, phase II funds have been aligned to support this measure and ensure its completion. Additionally, the PPS is implementing an analytics platform by June 2017. This DSRIP-specific platform with be utilized along with state resources such as MAPP and Salient to keep our partners informed of PPS CVD trends and outcome measures. In addition to sharing CVD Roadmaps, two partners shared their practice’s risk stratification tools at the February 2017 meeting. These tools, used along with their CVD registries and PPS analytics, will allow the practices to develop and identify gap lists in order to schedule patients for follow up visits.

Individual Patient Support:

EHR prompts to complete 5A's of tobacco control (M5): The CVD Subcommittee first created and approved a list of all the structured data elements including the 5 A's of tobacco control, necessary for partners to capture in their EHRs in order to satisfy the project's requirements (CVD Roadmap). The PMO will share the "Treating Tobacco Dependence Practice Manual" developed by American Academy of Family Physicians as well as the Million Hearts Action Guide, "Identifying and Treating Patients Who Use Tobacco" to guide practices in implementing necessary workflow changes to achieve the objective. Additionally, as part of ongoing monitoring of implementation activities, phase II funds have been aligned to support this measure and ensure its completion. With the addition of actions described above as well as the updated implementation plan, the PPS is confident all metrics in this milestone will be completed by 9/30/17.

Prescribe once-daily or fixed-dose combination pill regimens (M11): The PPS has completed considerable work toward once daily regimens or fixed dose combination pills since the September submission. The CVD subcommittee chose the JNC 8 algorithm for medication management for contracted partners to incorporate into their protocols for adoption and implementation. As part of Phase I contracts, these protocols were submitted in December to the PMO. As part of ongoing monitoring of implementation activities, in addition to the protocols submitted during phase I, phase II funds have been aligned to support this measure and ensure its completion. The PMO will track this measure through the submission of de-identified screenshots of the prescribed regimens captured in the EHR as we move toward continued transformation.

Facilitate referrals to NYS Smoker's Quit Line (M16): In addition to the 5A's the PPS is also refining efforts toward referring applicable patients to the NYS Smoker's Quitline. The PPS has already created referral policies and procedures as part of Phase I and this documentation was included in September reporting. In addition to the policies and procedures, we will strategize through working with our EHR subcommittee in assisting contracted partners to develop a process utilizing registries or when completing the 5A's of tobacco control to identify and refer patients to the NYS Smokers Quitline and utilize the EHR to track and monitor those patients for further follow up. Phase II is also aligned to require a roster of de-identified unique patients that were referred to the Quitline using the processes developed which will assist the PPS to be able to track and monitor the completion of this milestone.

Tracking Progress:

AMCH PPS will track progress through a robust set of contract metrics. Clinical leads from across the PPS were invited to participate in the development of Phase II contracts. The metrics will directly impact deliverables and align with the 3.b.i action plan. Roles and responsibilities of partners are defined in the contract metrics. In several cases metrics may be defined as hurdle metrics or bundle metrics, to ensure successful completion of tasks that are necessary in order to effectively implement the project. For example, the PPS is linking project incentives to implementing staff training and competency assessment of the measurement of blood pressure, which is a metric that is bundled with other metrics that will direct appropriate identification and management of patients with hypertension. The PPS will also utilize a data analytics tool that will leverage data sources such as MAPP to provide analytics specific to our PPS and projects.

Contracted organizations will continue to be represented on clinical committees and subcommittees, as noted in the Primary Care Plan. AMCH PPS will continue to engage Practitioners (PCPs & Non-PCPs), Hospitals (Inpatient & ED units), Clinics, Health Homes, Pharmacies, Local Health Departments, and CBOs in the oversight of 3.b.i as appropriate. CBO engagement provides valuable resources and insights into addressing social determinants of health. Productive discussions have also ensued with Albany County Health Department to support the home blood pressure monitoring initiative.

Hypertension and other cardiovascular diseases are also eligible conditions for the Health Home At Risk Project, which is currently piloting a program with CMH and 4 care management agencies (CMA.) As noted in the Primary Care Plan, BHNNY (Better Health for Northeast NY) Cares care coordination/ care management program will work with downstream health home CMAs and other regional partners to support transitions of care for patients discharged from ED or hospital, and direct to appropriate resources such as community care coordination, and health home services, further strengthening services and linkages for patients with cardiovascular conditions.

The AMCH PPS activities align with the overall DSRIP project objectives by assisting practitioners to improve the overall health status of patients with CVD and implementing the Million Hearts strategy in order to support these efforts. By aligning these efforts in the CVD project with the overall DSRIP goals, we will reduce avoidable hospitalizations and ED admissions for patients with CVD. The AMCH PPS is committed to the completion of this project and confident that we will meet the project timeline of 9/30/2017.

Mid-Point Assessment Recommendation:

Project 3diii Recommendation 4: *The IA recommends that the PPS develop a corrective action plan to successfully complete the project requirements that the IA determined were not completed by the PPS Speed & Scale commitment date for this project. The PPS must provide a revised timeline for the completion of the three project requirements that were not completed by DY2, Q2 as part of this action plan.*

PPS Action Plan Narrative:

The AMCH PPS is identifying additional meaningful tasks to support the overall project objective of implementing evidence based medicine guidelines for asthma management to ensure consistent care. While the PPS has faced challenges, including an aggressive speed and scale timeline matched with the absence of capital funding to promote advanced technology and innovation, the PMO is confident that continued, innovative collaboration within the participating provider network will help to alleviate said challenges. . The risk score of this project increased from 3 to 4, indicating the project may not meet intended goals without significant modifications or performance improvements. Unofficial feedback on the appeals that was provided to facilitate our MPA response indicated that the PPS did not complete completed three out of the five DY2Q2 project requirements. We have used experiences from missed and completed milestones to strengthen the approach outlined by our action plan. The PPS has taken steps such that the action plan will be effective and meaningful to the project, and support the implementation of evidence-based medicine guidelines, utilization of asthma action plans (AAP), and access to specialists.

The corrective action plan put in place to address milestones that were not completed by 9/30/2016 includes several components: refining/identifying additional tasks and timelines, including the implementation of a Project ECHO/ telemedicine platform, focusing on and continuing to improve patient and provider engagement numbers, and continuing to build on success that was attained through DY2Q2. For example, while Milestone 3 (provider education) was completed, educational activities will be ongoing throughout the course of DSRIP. Data from sources including the 2016 HCDI Community Needs Assessment and February 2017 Asthma Health Equity Report from HCDI continues to inform how we will prioritize and focus tasks to address the asthma burden in our region – for example Albany sees a significant disparity in asthma hospital and ED use for its lowest income neighborhoods.

Milestone 1: The updated implementation plan includes revised steps for both metrics. The PPS believes that the IA's comments address Metric 2 (All participating practices have a Clinical Interoperability System in place for all participating providers.) AMCH PPS has created an EHR Subcommittee, which began meeting in DY2Q2. The first charge was the asthma project, and working with those partners, as the PPS works towards a PPS-wide registry in order to take a population health approach to managing its asthma patients. With assistance from the Asthma and EHR subcommittees, use of updated and consistent asthma templates will allow for standardized data collection, identification of patient cohorts, and accurately capturing the use of asthma action plans (AAPs). Furthermore, all practices participating in the asthma project have EHRs and agreements in place with HIXNY. The challenge will be in "flipping the switch" to ensure that information is flowing through this channel. The PPS and Project Subcommittee continue to focus on leveraging collaboration efforts, best practices, effective processes, and strategies to improve outcomes for our patients with asthma. One item frequently discussed due to its impact on our patient engagement is the ways in which AAPs are documented and distributed. The Subcommittee has had partners share their AAP workflows and any best practices from their sites.

These range from having a partner create and integrate an electronic AAP into their workflow, to partners who have EHRs that come with the AAP pre-built, to partners who utilize the paper forms. These include Primary Care offices, multi-specialty offices, pediatricians, general family medicine, and home based services.

Milestone 2: The updated implementation plan includes revised steps for the three metrics. Co-management agreements between PCPs and specialists will continue to be executed and leveraged to provide a framework for better communication and safe transition of care, as well as optimal health care, consistent with national asthma guidelines. The PPS believes that the IA's comments address Metric 2 (EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.) The tasks here align with those for Milestone 1, Metric 2. The PPS maintains a close relationship with Hixny and we work collaboratively with both existing and newly contracted partners to establish bi-directional connectivity. The PPS has also revised the approach to Metric 3 (Telemedicine service implemented.) The PPS did not receive capital funding, which has redirected the PPS to options that can utilize existing equipment and services/ resources to the extent possible. Additionally, within AMCH PPS counties, there are considerable inconsistencies in broadband access. Efforts currently exist at the state-level to support widespread broadband access across the state, to unserved and underserved homes and businesses. Furthermore, PPS partners encompass a wide range of technical capabilities and technologies. Project ECHO, developed by University of New Mexico, has been proposed as an alternative to traditional telemedicine. This serves as a "tele-mentoring" program, with regular conferencing between PCPs and specialists. Project ECHO acts as a force multiplier, training PCPs to provide specialty care services and establishing a large group of PCPs with expertise in asthma care while enabling patients to receive needed care in a timelier manner. This leads to better outcomes for the patients, and for the PPS. This model can enhance provider engagement, as well as the education component of this project. The PPS has achieved a level of buy-in for Project ECHO in the form of a clinical champion, a specialist and PCP group, and a hospital. Project ECHO has a solid evidence base and the PPS Finance Committee is also supportive of the funding of this model.

AMCH PPS will track progress through a robust set of contract metrics. Clinical leads from across the PPS were invited to participate in the development of Phase II contracts. The metrics directly impact deliverables and align with the 3.d.iii action plan. Roles and responsibilities of partners are defined in the contract metrics. In several cases, metrics are defined as pre-requisite metrics or bundle metrics, to ensure successful completion of tasks that are necessary in order to effectively implement the project. For example, the PPS is linking project incentives to AAPs, which is a metric that is bundled with other metrics that will direct appropriate identification and management of asthma patients. The PPS will also utilize a PPS-wide, data analytics platform that will leverage data sources from the DOH specific to Claims/Member Roster, Participating, contracted organizations, MAPP, Salient Interactive Miner, and Flourish to provide analytics specific to our PPS and projects.

Contracted organizations continue to be represented on clinical committees and subcommittees, as noted in the Primary Care Plan. AMCH PPS continues to engage Practitioners (PCPs & Non-PCPs), Hospitals (Inpatient & ED units), Clinics, Health Homes, Pharmacies, Local Health Departments, and CBOs in the oversight of 3.d.iii as appropriate. CBO engagement provides valuable resources and insights into addressing social determinants of health and environmental assessment and trigger education at the home level. Productive discussions have also ensued with The Center for Disability Services, and in all likelihood they will come on board for 3.d.iii. Specialist engagement has proven challenging, due to patient care demands; however, our lead hospital has recruited a Pulmonologist with an interest in

asthma, to start in March 2017. Columbia Memorial Health (CMH) has identified a Nurse Practitioner who has championed previous asthma efforts and will work as a nurse liaison across CMH sites to support engagement and implementation of the asthma project.

Asthma is also an eligible condition for the Health Home At-Risk Project, which is currently piloting a program with CMH and four care management agencies (CMA.) As noted in the Primary Care Plan, BHNNY (Better Health for Northeast NY) Cares care coordination/ care management program will work with downstream health home CMAs and other regional partners to support transitions of care for patients discharged from ED or hospital, and direct to appropriate resources such as community care coordination, and health home services, further strengthening services and linkages for asthma patients.

Mid-Point Assessment Recommendation:

AMCH PPS Recommendation 5- Community Based Organization Contracting:
The IA recommends that PPS develop a clear strategy for contracting with CBOs

AMCH PPS Recommendation 6- Community Based Organization Contracting:
The IA recommends that the PPS finalize contracts with partnering CBOs.

PPS Action Plan Narrative:

Community Based Organization Engagement| What have we done:

There is no way around it; health starts in our homes, neighborhoods and communities. As a result, collaboration with CBOs is essential to the success of DSRIP. The AMCH PPS appreciates the relationships; trust and instrumental role CBOs have in assisting individuals make the choices that lead to good health. The AMCH PPS is working with CBOs to establish common goals, complementary roles, and ongoing constructive relationships within the network through continued efforts to address social determinants of health. The AMCH PPS continues to partner with CBOs and engage in two-way dialogues specific to identification of gaps, goals and the ability to leverage the DSRIP resources. CBOs are creating social and physical environments that promote good health while providing social and economic services/resources that will keep community members out of the emergency department as a means to help transform the health care system of New York State. The AMCH PPS PMO has appointed a *Community Relations Manager* as a single point of contact devoted to not only engaging the community, but maintaining and fostering collaborative relationships/partnerships with CBOs. In an effort to maximize opportunities, the *Community Relations Manager* is scheduling face to face meetings with Tier 1 CBO personnel and others to explore how programs, practices, and policies in these areas affect the health of individuals, families, and communities. Meetings have started and will continue through June 30, 2017. Meeting agendas will include DSRIP overview/goals, projects overview, Patient Activation Measure®, CBO mission/services/resources and Domain 4 activities. For CBOs that do not currently have a POA/BAA in place with the AMCH PPS, these meetings are utilized in a valuable and methodical way to discuss varying participation levels and contractual agreements. The AMCH PPS has CBOs actively participating in committee meetings and at events that, at this time, choose not to sign a formal contract. This does not limit the organizations from having a voice at the table. Additionally, these meetings are places where the PMO can learn more about services provided by an organization and help them to align these services with project participation.

Since the early stages of DSRIP the AMCH PPS PMO recognized the rich knowledge and expertise of CBOs. In addition to community resources, CBOs possess unique relationships with the Medicaid population - relationships built on compassion, trust and respect. Many of the CBOs across the AMCH PPS catchment area have been working with beneficiaries for decades to address social determinants of health and to help improve their quality of life. This said; the AMCH PPS values the role of the CBOs in both DSRIP and the community. The PPS continues to work collaboratively with CBOS on a daily basis and holds in high regard their ability to be family/neighborhood/community resource centers for the community at large.

The AMCH PPS established a Consumer and Community Affairs Committee (CCAC) in May, 2015 which is charged with representing the interests of Medicaid recipients and the uninsured while providing feedback and recommendations to the PAC regarding the unique needs of consumers and how these needs can be met throughout DSRIP. CCAC membership consists of members from CBOs, hospitals and

local government agencies. CCAC membership will remain open through the lifespan of DSRIP. The AMCH PPS is honored to have the CCAC chairing responsibilities shared between two partnering CBO representatives; Mr. William Faragon of The Alliance for Positive Health and Mr. Marcus Harazin of New York StateWide Senior Action Council. Both were instrumental in the development and approval of the AMCH Community Engagement Plan (CEP).

The development of a Community Engagement Plan (CEP) was one of the key tasks assumed by the CCAC as this was one of the elements of their mission and charter. The CEP is based on community-led feedback received as part of the CCAC's continuing engagement activity which includes outreach to schools, churches, homeless service organizations, housing providers, law enforcement, health planning agencies and community-based service providers. The CEP is designed as a dynamic document which includes descriptions of the regional area, identified hot spots, strategies to engage the community, consumers and CBOs as well as a communication strategy and outreach activities. Those outreach activities continue as part of ongoing community engagement efforts, and as part of the implementation of the CEP. This document continues to grow as new service needs or service opportunities are identified throughout the five-county region. The AMCH PPS utilizes their public facing website (www.albanymedpps.org) to facilitate community involvement and provide the necessary communication to our partners.

Due to the challenges of getting Medicaid recipients to the table, CCAC has sponsored listening sessions across AMCH PPS's five-county catchment area as a means to allow Medicaid Beneficiaries to speak openly and honestly about their concerns, experiences, and thoughts of how to improve the system of care. To date, 29 listening sessions have been conducted by a total of 10 CBOs who have received funding to facilitate: Center for Disability Services, In Our Own Voices, Independent Living Center, St. Catherine's, Trinity Alliance, Wildwood, Alliance for Positive Health, Alvarado-Little Consulting, Promesa, Inc., and NY Statewide Senior Action Council. As a result of the unique community relationships of our CBO partners, listening sessions were facilitated where beneficiaries were accessible and already spending time. Ironically, beneficiaries could be reached in other CBOs such as housing providers, churches and family support services.

During the month of March, the PPS is working with Medicaid beneficiaries from various CBOs to conduct focus groups centered on program development for preventative care and efficient methods of awareness. The first session took place on March 2nd at Camino Nuevo. Over 20 participants were in attendance. These advisory meetings will continue throughout 2017 in both group, and one-on-one settings. In addition, the PMO is distributing an RFP to network partners targeting patient education of preventative services. The focus of this RFP is to engage CBOs to conduct education of preventative services to patients in their community. This will support AMCH PPS contracting with and flowing funds to CBOs for these preventative services in support of population health.

The CCAC has also hosted and will continue to host, regional forums for DSRIP informational purposes; these forums are community focused and are held in collaboration with overlapping PPSs to ensure the proper alignment of a clear and concise message to participating providers, community organizations, and Medicaid Beneficiaries. The CCAC continues these discussions as they host their monthly committee meeting in our northern, southern, and central hub locations, allowing for face to face participation in each region.

The AMCH PPS participates in community led events and also holds a seat at many community based meetings including COReSTAT, LEAD, HCDI, PHIP, SHIP, and CHIP. The AMCH PPS, along with its participating providers – mainly those who are community-based organizations – have collaborated in events such as the CUT Hypertension initiative, The Delaware Ave Community Event, Albany Community Action Partnership 50th Anniversary Block Party, and YMCA's "Voice Your Vision" among many others. By participating in these events, the AMCH PPS is increasingly aware of the CBOs in our region, the services they provide, and how we can collaborate in order to provide quality care for patients.

As a means to engage patients in the IDS, the AMCH PPS has opted to utilize the Patient Activation Measure ® (PAM) assessment tool, which is an evidence-based tool that reliably predicts future ER visits, hospital admissions and readmissions, based off of consumer health characteristics for a multitude of prevalent health conditions. As a result, conducting PAMs in the high-need areas will help to improve the overall health and well-being of the population. To date, the AMCH PPS has provided PAM ® and Coaching for Activation (CFA) training to a total of 16 CBOs – Alliance for Positive Health, Black Nurses Coalition, Catholic Charities, Community Caregivers, Healthy Capital District Initiative, Columbia County Community Healthcare Consortium, Inc., Independent Living Center of the Hudson Valley, Inc., Mental Health Empowerment Project, Northern Rivers, Planned Parenthood Mohawk Hudson, Upper Hudson Planned Parenthood, The WILLOW program, Capital District Center for Independence, Shelters of Saratoga, St. Catherine's Center for Children and Trinity Alliance. This intensive and thorough training covers a wide array of patient activation techniques such as shared decision-making, measurements of health literacy and cultural competency – and will provide these CBOs with the necessary skills and fundamental understanding of how to properly engage with and administer the tool. The majority of partners who are actively administering the PAM ® are those that are considered CBOs. CBO partners have community health workers providing connecting and/or reconnecting beneficiaries to designated PCPs. Culturally competent CBOs assist the PPS with identifying hot spots for outreach and health navigation activities in key communities where the underserved are located.

In March 2016 the AMCH PPS was given the opportunity to undertake one of its most innovative collaborations. Partnered with two CBOs, the Albany Police Department and Catholic Charities, the PPS went into contract to fund an initiative aimed at reducing low-level arrests, racial disparities and recidivism with the implementation of the Law Enforcement Assisted Diversion (LEAD) innovative criminal justice program. Leveraging the nationally renowned project, the LEAD case management function in Albany was supported by Albany Medical Center which was able to provide funds to jumpstart the program's first phase of case management services. The AMCH PPS's innovative funding of LEAD is an important step in the shift from a criminal justice-based approach to a health-based approach with issues related to drug use and mental health. In LEAD, instead of making an arrest, police officers exercise their discretion to divert individuals for certain criminal offenses (including low-level drug charges) directly to a case manager, who then facilitates access to a comprehensive network of services. Instead of entering the maze of the criminal justice system, the individual receives intensive, harm reduction-oriented case management and targeted social services, with greater coordination among systems of care.

Community Based Organization Engagement| What we plan to do:

Moving forward, the AMCH PPS will continue to participate in community led events as well as continue to engage neighborhood/community CBOs such as barbershops, churches and education centers. The PPS will also work closely with the *S2AY Rural Health Network* to identify technical assistance needs of CBOs and educate them on resources and subcontracting pertaining to DSRIP. The CCAC and *S2AY Rural Health Network* are scheduled to meet April 2017 to discuss the CBO Needs Assessment.

Additionally, through the efforts of the CCAC, the PPS will schedule and facilitate networking sessions for CBOs both in and out of network. These events will be designed to communicate the current and future states of DSRIP and the PPS; along with gathering information from CBOs regarding community resources, and services, and technical assistance needs will be a topic of discussion.

The AMCH PPS will continue to engage and leverage Tier 1 CBOs for their expertise at the committee level, their knowledge and support at community events as well as best practice sharing via face to face meetings. Tracking of Tier 1 CBOs new to the network will be documented through the execution of BAA and POA. It is important to note that some CBOs may choose to be engaged, but may not enter into contracts due to a lack of resources and the inability to commit to deliverables. AMCH PPS has currently entered into partnership agreements with the following Tier 1 CBOs; Albany County Woman and Infant Linking Lifetime Opportunities for Wellness, Black Nurses Coalition, Catholic Charities, Community Caregivers, De Paul House Management, Healthy Capital District Initiative, In Our Own Voices, Independent Living Centers of Hudson Valley, Mental Health Empowerment Project Shelters of Saratoga, Trinity Alliance and Wildwood Programs among others. Domain 4 projects, along with 2.d.i, 3.b.i and 3.d.iii will be the focus for CBO contracts. All provider types within the AMCH PPS that have an executed POA and BAA can receive a phase II contract for participation in projects they are interested in and eligible to participate in. This is also true for CBOs. Funding will be allocated and distributed based on successful contract deliverables being met over the next 15 months. These contracts are designed to complete milestone metrics, and improve outcome measures. Contracts are being developed and implemented to include CBOs in our centralized care management model. These contracts will leverage and enhance existing services provided by CBOs in our region to create a cohesive support system for patients in need of care.

Lastly, feedback of beneficiaries is extremely important in the development and promotion of preventative care. RFPs for Consumer Listening Sessions will continue to be issued across the PPS service area and for beneficiaries' feedback pertaining to healthcare best practices, needs and barriers. Feedback will be documented and handed off by CBOs and other partners to the PMO and onto NYSDOH. The PMO will also facilitate consumer workgroups work with beneficiaries in collaboration with partnering CBOs.

Recommendation 6: Finalize Contracts with CBOs

As mentioned above, the AMCH PPS will continue to engage and leverage CBOs for their expertise and services among community members. The strategy the AMCH PPS has to finalize these contracts is well outlined above but a few additional notes are important to response to this recommendation. Several CBOs continue to actively participate in committee meetings and have chosen to not have a formal contract in place. The Community Relations Manager and lead of the Consumer and Community Affairs Committee, continues to meet with these CBOs to provide an overview of project activities and how

their services could play a vital role in implementation. In addition to the strategy as outlined in Recommendation 5 to contract with CBOs within the network, the PMO continues to engage and interact with all types of community advocates, community based organizations, and other community type events. Since midpoint in September of 2016, an additional CBO signed formal agreements to participate in the AMCH PPS in a more structured way and several CBOs have joined the 2di project. This will allow funds to flow to these CBOs for the service enhancements they need to support DSRIP.

Mid-Point Assessment Recommendation:

AMCH PPS Recommendation 7

Cultural Competency and Health Literacy: The IA recommends that the PPS develop an action plan to implement its CCHL trainings to partners.

PPS Action Plan Narrative:

There are clear linkages between health outcomes and social determinants of health. Disparities in care have many causes, including institutional racism, stigma, and barriers to care that are based on culture, language and literacy. The Cultural Competency and Health Literacy Committee (CCHLC) was established in May 2015 with various representatives from PPS partner organizations that serve diverse population of patients including elders, LGBTQ individuals and those with addiction issues. This Committee meets regularly, generally monthly, to develop strategies and recommendations for culturally and linguistically appropriate services to meet DSRIP goals. The Committee is chaired by Tandra LaGrone, the Executive Director of In Our Own Voices, an organization dedicated to serve LGBTQ people of color community. The CCHLC has successfully completed two milestones, including the Cultural Competency/Health Literacy Strategy and the Cultural Competency Training Strategy. These two documents continue to guide the AMCH PPS's future implementation of various CC/HL-related trainings and organizational changes.

To date, the AMCH PPS has already implemented several initiatives and trainings for our participating organizations. Wilma Alvarado-Little, an expert in cultural competency and language access, hosted the webinar titled, "Introduction to CCHL Training" on September 29, 2016. The PPS had over 100 attendees for this event, covering all contracted organizations and provider types. This training was recorded for future dissemination and is posted on the AMCH PPS website. Additionally, the first Bridges Out of Poverty session was completed on February 23 and 24, 2017. There were over 50 attendees from 14 partner organizations in attendance, for the two full-day sessions, to learn about the mental model, hidden rules and language of poverty and how they can utilize those in better serving patients/clients living in poverty. Lastly, the AMCH PPS has held four CC/HL Champion meetings since June 2016. Each of these meetings is held in person with a web/call-in option and are recorded for future review and reference. CC/HL Champions are representatives from each contracted organization to act as a liaison in implementing CC/HL-related initiatives and trainings. The format of the champion meetings has transformed from discussing best practices to bringing guest speakers on CCHL-related topics to engage in educational discussions. More recently,Dr. Jennifer Manganello, a health communication expert from UAlbany SUNY School of Public Health, and Tandra LaGrone and Gabby Santos from In Our Own Voices were invited speakers for the topics of to speak about health literacy and LGBTQ-related issues, respectively.

The AMCH PPS has the following plans for CCHL training implementation to be completed by September 30, 2017. In January 2017, AMCH PPS PMO staff began meeting with individual CC/HL Champions to discuss organization-specific action steps for disseminating the "Intro to CCHL training" information within their organizations. During these 60- to 90-minute meetings, there are also discussions of other DSRIP-related training needs and communication-related concerns. Thus far, we have met with seven partners and will continue to have one-on-one conversations with all 70+ contracted partnering organizations. Within the Phase II contracts, partners are held accountable for providing this training to at least 80% of affected persons in their organization by March 2018, in order to receive payment for this metric. The AMCH PPS plans to continue hosting two-day Bridges Out of Poverty training on a quarterly basis. Locations and dates will be determined by partners' feedback. Additionally, after hosting

three sessions through Schenectady Bridges, we will evaluate the interest level for three-day train-the-trainer program in order to conduct this training more frequently. The AMCH PPS and the Alliance for Better Health Care are in the final stages of planning and publicity, to co-host a Health Literacy Symposium on March 23, 2017 with a physician speaker and content expert in health literacy, Dr. Michael Paasche-Orlow from Boston University School of Medicine. This CME event will host 200 attendees to spark interest about health literacy, particularly among clinicians and frontline care providers. This event is being publicized in many ways, including flyers, email, word of mouth at all provider committees, etc. Lastly, the AMCH PPS will continue to host quarterly CC/HL Champion meetings with one or two speakers for each meeting. When the opportunity arises, the AMCH PPS will collaborate with our neighboring PPSs to combine CC/HL meetings to reduce duplication and encourage collaboration.

The AMCH PPS chosen Learning Management System, HealthStream, was originally slated for license distribution in December 2016 but was rescheduled to early this year due to overlap challenges, registration needs, and technical issues. The AMCH PPS is collaborating with neighboring PPSs to target audiences most affected to appropriately distribute licenses and accounts. We also plan to upload training modules, including DSRIP 101 and introductory CCHL-related content, that can best be delivered online vs. in-person. Once disseminated, we will track and monitor the training completion with pre- and post-training assessments and course evaluations. Trainings are directly related to phase II contracts and therefore payment is dependent upon completion. This holds the PPS responsible for providing appropriate trainings as well as providing incentive for participating organizations to complete all trainings.

As outlined in the midpoint implementation plan template, there are four PPS-defined milestones to be completed by 9/30/17 and one PPS-defined milestone to be completed by 6/30/17. In order to track progress in executing the actions, AMCH PPS will extensively utilize pre- and post-training assessments and evaluations to get feedback from training participants and to improve future training experiences for partners. As mentioned in our Cultural Competency Training Strategy, we gather feedback regularly from CCHLC, CC/HL Champions and Consumer Listening Sessions to shape our training implementation going forward.

These implementation activities will support the PPS's overall goal of increasing awareness about cultural competency and health literacy in order to improve patient outcomes. We valued partners' feedback as we first implemented introductory training on CCHL and Bridges Out of Poverty trainings were among the top three interested training areas. Furthermore, we believe continuous engagement of CC/HL Champions and maximized use of HealthStream will greatly help disseminate CCHL-related information to even larger audiences. We consider that an event like the Health Literacy Symposium is an excellent strategy to attract partners and raise awareness about a topic that is often not discussed.

Mid-Point Assessment Recommendation:

AMCH PPS Recommendation 8- Primary Care Plan: The IA recommends that the PPS develop a detailed action plan to articulate what parts of the current Primary Care Plan have been implemented. The IA also recommends that this plan defines the planning phase and implementation phase discretely.

PPS Action Plan Narrative:

The AMCH PPS has updated the Primary Care Plan document and developed an action plan. The changes made to the document reflect the recommendation provided by the IA, as well as the overall assessment provided in December 2016 that: "Plan is not clear on what has been implemented and what might be implemented, but it appears many activities are still in the planning phase. Detailed description of PCP participation in different committees and subcommittees. Funds flow for Phase 1 described, though unclear if funds distributed (Plan states funds have been allocated). Funds flow for the next phases are not described." Consistent with the midpoint timeline, the PPS identifies milestones and tasks to be completed through 9/30/2017 in the action plan.

The Primary care is essential in improving patient health and providing equitable access to health care to help reach DSRIP goals. The AMCH PPS recognizes that a seamless linkage between episodic care, such as hospital inpatient and emergent care services, and primary care is critical to ensure a full continuum of care for our patients. By working directly with primary care practices and other secondary and tertiary service providers, the AMCH PPS will continue to act as a liaison and foster relationships between providers.

The AMCH PPS has Master Project Agreements with three hospitals employing 162 PCPs, two large community-based primary care groups employing 237 PCPs and several community-based pediatric practices. PCPs participating in the AMCH PPS have given considerable thought to the role that primary care will have for the transformations that will be brought by DSRIP, and the years that will follow.

The information contained in the primary care plan includes a review of available data and insight to what has been accomplished across the PPS. This includes activities that have been implemented along with those that are not yet in place but have more clearly defined timelines and commitments, along with those that are still in need of further discussion but are still under serious consideration. There are also several items identified as Expansion of Primary Care Capacity and services: Additional Approaches: Plans for Future Consideration which includes a higher level list of incentives that may be considered to support partners with acquiring necessary resources as they work to expand access.

The Primary Care Plan has been reorganized to more clearly present what has been implemented or is currently underway, what is being planned, and what is in discussion/ under consideration for PCMH recognition, transition to VBP, and integration of primary care and behavioral health. We also expanded upon alignment with CPC+.

The revisions provide further detail of funds distribution for Phase I (4/1/15-12/31/16) and funds flow plans for Phase II (1/1/17-3/31/18). Funds are allocated based on provider type, project participation, and attributed lives. $9.7 million was allocated to partner organizations during Phase I, and Primary Care providers represent over 77% of this allocation. As of February 2017, approximately $4.7 million of the

total $5.6 million distributed was to organizations that offer primary care. The PMO is actively working with partners to complete several deliverables that will yield an additional $3-4 million in distributions. Phase II contracts have approximately 85% of funds allocated to partners that offer primary care services. The contracts are expected to be released for execution by 3/10/2017.

It is anticipated that the third phase of contracting will include predominantly outcome measure metrics to support and ensure that the primary care partners within our network are actively working toward the end goal of providing better patient care, reducing unnecessary ED visits and inpatient readmissions, and increasing population health.

The PPS developed an action plan to accompany the Primary Care Plan. The action plan includes tasks that the PPS has completed as well as tasks that will be completed by 9/30/17. There are multiple mechanisms through which the PPS will track progress made on the Primary Care Plan. Phase II contracts have metrics associated with several identified tasks that hold partners accountable to completion. Pre-requisite and bundle metrics require completion in order to be eligible for payment and to ensure successful completion of tasks that are necessary in order to effectively drive system transformation. The implementation plan will be reviewed quarterly with the Primary Care Advisory Group to assess status and progress as well as the AMCH PPS Board of Directors' Clinical & Quality Affairs Committee. The AMCH PPS will also track PCMH and grant metrics to monitor performance.

The AMCH PPS recognizes that a seamless linkage between episodic care, such as hospital inpatient and emergent care services, and primary care is critical to ensure a full continuum of care for our patients. By working directly with primary care practices and other secondary and tertiary service providers, the AMCH PPS will continue to act as a liaison and foster relationships between providers.

NEW YORK STATE | Department of Health

DSRIP Primary Care Plan

PPS Name: Albany Medical Center Hospital

Assessment of current primary care capacity, performance and needs, and a plan for addressing those needs.

- **PPS's over-arching approach for expanding Primary Care capacity and ensuring the provision of required services (including, as appropriate, addressing gaps in Primary Care capacity)**
- **How is the PPS working with community-based PCPs, as well as institution-based PCPs?**

Primary care is a critical component to the success of DSRIP, and AMCH PPS has maintained a focus on improving access to care. A consumer survey of Medicaid enrollees in the region showed that 29% of respondents used the emergency room as their usual place to receive healthcare services as it was the most convenient for them at the time of needing care. Of those who used the ED as their primary source for care, 59% used it three or more times in the year prior. Medicaid primary care visits are lower than the NYS average in 4 out of 5 counties in the AMCH PPS Region. The AMCH PPS has utilized the PPS Network Analysis, Community Needs Assessment data, Partner Network Survey, compensation and benefits information, Workforce Target State Report prepared by BDO Consulting, and partner feedback to make and execute plans that are informed and relevant. Many of the needs that have been identified relate to the actual number of providers that are within a practice. The ability to recruit providers to support practice expansion varies by practice. Providers consistently raise the issue of expanding in order to offer weekend and evening hours in an effort to operate "clinics" that could potentially divert avoidable ED use that occurs out of convenience, or without considering that another option may be available.

The AMCH PPS has Master Project Agreements with three hospitals employing 162 PCPs, two large community-based primary care groups employing 237 PCPs and several community-based pediatric practices and FQHCs employing 35 PCPs. PCPs participating in the AMCH PPS have given considerable thought to the role that primary care will have for the transformations that will be brought by DSRIP, and the years that will follow.

The information that follows in this section includes a review of available data and insight to what has been accomplished across the PPS. This includes activities that have been implemented along with those that are not yet in place but have more clearly defined timelines and commitments, along with those that are still in need of further discussion but are still under serious consideration. There are also several items identified as Expansion of Primary Care Capacity: Additional Approaches: Plans for Future Consideration which includes a higher level list of incentives that may be considered to support partners with acquiring necessary resources as they work to expand access.

The **PPS Network Analysis** included the following information for the AMCH PPS PCPs:

Data provided by DOH combined with PCMH recognition data as of February 2017

- Total PCPs in PPS: 495

- Total # PCPS participating in multiple PPS: 319 (64.4%)
- % PCP/ Extenders offering after-hours care: 27.7%
- Average total care hours: 36 hours
- % PCPs accepting new Medicaid members: 87.9%*
- Total PCPs at sites with PCMH 2011 Level 2: 0
- Total PCPs at sites with PCMH 2011 Level 3: 141
- Total PCPs at sites with PCMH 2014 Level 2: 0
- Total PCPs at sites with PCMH 2014 Level 3: 55

**Note:* Based on the feedback from our participating partners, the % of PCPs accepting new Medicaid members as listed above is not an accurate reflection of the current state. Significant numbers of new Medicaid patients face delays in finding a PCP who is able to accept new Medicaid members within a reasonable time period. In 2015, a PPS wide survey that was conducted to assess access to primary care services showed that the average third next available appointment for new adult patients among our key safety-net practices was 24 days, ranging from 4 to 38 days. This demonstrates disconnect between the data from the Provider Network Data System (PNDS) and the reality faced by our Medicaid beneficiaries.

Current State Assessment: Medical Practice Types

As part of the current state assessment of PPS practitioner capacity, AMCH PPS completed a participating partner survey in October, 2015, that yielded the following distribution of primary care providers across the network.

Medical Practice Type (multi-selection) (n=86)

# of Primary Care types: 26
- Geriatrics: 8
- Primary care: 6
- Family Medicine: 5
- Pediatrics: 4
- Internal Medicine: 3

# of BH practice types: 23

Given the proportionately fewer primary care practices across the network as compared to the number of specialist practices, timely access to primary care services in certain zip codes will be a priority as we pursue various strategies outlined in this document.

Primary Care Practitioner Composition:

Based on the compensation and benefits information that we received from most of our participating partners as part of our Workforce workstream deliverable, the following is the breakdown by practitioner and facility types:

# of Primary Care Practitioners: 323
- Physicians: 187
  - Article 28 PC facilities: 55
  - Non-article 28 PC facilities: 120
- Nurse practitioners: 74
  - Article 28 PC facilities: 20
  - Non-article 28 PC facilities: 48

Physician Assistants: 62
Article 28 PC facilities: 16
Non-article 28 PC facilities: 45

As we look at strategies to expand primary care services, increasing the number of Advance Primary Care Practitioners at our partner sites will be one of the areas of focus to support the expansion of the Team-based care model across all our primary care sites.

MAPP Data Analysis:

Analysis of PPS wide data available on NYSDOH Medicaid Analytics Performance Portal (MAPP) has provided us with valuable information on maldistribution of primary care services by specific ZIP codes within our PPS region. Not surprisingly, Albany and Greene counties with urban and rural populations have the highest number of ZIP codes with maldistribution of PCPs to attributed members. Within Albany County, 5 out of the top 10 ZIP codes (12206, 12202, 12189, 12210, and 12047) have limited PCP coverage based on members/PCP analysis, including 4 ZIP codes without a participating PCP located in their respective ZIP codes. Furthermore, the ratios of attributed members to PCP are significantly higher in Columbia and Greene Counties than the average ratio across our PPS. According to an internal analysis, the ratios for Columbia and Greene County are 358 patients per every 1 PCP and 631 patients per every 1 PCP, respectively. This is 2-3 times that which is observed for Albany, Saratoga and Warren Counties.

Needs Assessment:

The needs of the residents of the community were assessed using reported data, capturing first-hand accounts from consumer focus groups, reaching out to key stakeholders for input and analyzing survey data. AMCH's assessment of community need included the following sequential components.

First, the PPS conducted a comprehensive baseline assessment of the five-county region. This assessment identified provider locations, hours of operation, plans for future development, utilization and other volume indicators, payer mix, appointment availability and other critical items from all participating primary care providers who are part of the PPS network. The resulting data was collated and thoroughly analyzed. The data generally demonstrated a disparity between neighborhoods with the highest number of Medicaid enrollees and access to primary care, as measured by appointment availability, hours of operation and self-reported utilization data. The resulting "picture" that was "drawn" of the five-county region showed what the current state of care was in the catchment area. When matched with ED utilization data, clear patterns emerged. Results were statistically significant linking zip code, payer and race/ethnicity to predictive ability in terms of avoidable ED usage. A key variable, whether the patient had an identified primary care provider, proved to have a strong correlation with avoidable ED use and other health outcomes. In fact, over 70% of the Medicaid patients using AMCH's ED did not have an identified PCP. On further analysis of the data, it was clear that there were several "hot spot" areas with higher concentrations of patients without an identified PCP. These hot spot or underserved neighborhoods include Albany's South End and West Hill neighborhoods and the City of Cohoes.

Additionally, In Fall 2014, multiple regional community forums, focus groups and listening sessions were conducted in an attempt for the AMCH and Alliance for Better Health Care PPS's to collaboratively identify the barriers faced by consumers. Several barriers to the overall goal of reducing avoidable ED and hospital use were identified. Common themes that manifested during these sessions included:

- Confusion/knowledge gap
- Inconvenient service access

- Lack of transportation
- Home environment & living conditions (unstable housing, frequent moves, lack of social supports and communication resources)
- Lack of coordination & consistent follow-up
- High diagnosis rates of anxiety, depression and chronic conditions

Many patients, especially the working poor, may lack knowledge of the health care system, familiarity with and access to primary care and, as a result, make the emergency room their primary source of care. Expanding primary care hours of operation to accommodate the working poor will help. In addition, providing navigators at the point of entry of emergency rooms to triage patients' needs with a corresponding link to primary care that is convenient and accessible is necessary. Patients with multiple co-morbidities, especially those dually diagnosed with mental or emotional health issues and chronic illness, must navigate a system that is neither user friendly nor readily accessible. Service locations tend to be either primary care or behavioral health; rarely do they coexist. An additional change in the regional composition of providers that will help address this will be the co-location and integration of primary and behavioral health services. There may also be technologic solutions to some issues, modifying the provider mix by bringing the specialist to the PCP electronically. Changes that are implemented as part of the transformation process for PCMH will help to further build capacity and team-based approaches to care. This is described in greater detail in the following section(s).

The consulting firm, BDO, which also provided the Target Workforce State Report for Albany Medical Center Hospital Performing Provider System, will be making recommendations through the Workforce Transition Roadmap, which will guide long-term workforce development. According to the Workforce Target State Report prepared by BDO Consulting, the demand for primary care providers will increase as much as 50 FTEs by year 2020 (Target Workforce State Report for Albany Medical Center Hospital Performing Provider System.) This is a projection based on non-DSRIP changes, such as predicted changes in patient demographics, combined with DSRIP-dependent changes due to project implementation. This report clearly indicates a significant need for PCPs to meet the growing demand in our region, and suggests urgency for the AMCH PPS to address the PCP shortage issues with long-term solutions. Based on a brief hotspot analysis and feedback from PCPs, the AMCH PPS Project Management Office (PMO) has recognized the ways in which various practices are identifying and prioritizing solutions at their respective sites. A particular theme is the need for providers, and resources to supplement their income.

Moreover, the combined impact of a growing and aging population and expanded medical insurance coverage will increase demand for health providers by approximately 3-6% for the population of the AMCH PPS—with the amount differing by health occupation and medical specialty, and with much of this increase driven by the growing needs of the Medicare population. While the DSRIP projects are largely targeted at the Medicaid and uninsured populations, most providers in the PPS network also provide services to the Medicare and commercially insured populations. In addition, DSRIP has the potential to increase demand for some provider types, such as PCPs (Target Workforce State Report for Albany Medical Center Hospital Performing Provider System).

Expansion of Primary Care Services – Activities that have been implemented:

Albany Family Medicine, a division of Community Care Physicians, P.C., located in Albany County providing primary care services to a large number of our attributed members has brought on two new physicians and has increased patient slots for family medicine residents. Two part-time providers will be added in the

Summer of 2017.

Harmony Mills Pediatrics has added an early morning walk-in clinic.

Whitney M. Young Jr. Health Center has recently hired a RN coordinator to conduct walk-in blood pressure screenings and improve the quality and access of hypertension care for patients, while creating additional capacity within PCP schedules.

Center for Disability Services has increased their primary care capacity from 1.5FTEs to 2.9 FTEs and is also in the process of hiring a patient educator.

Columbia Memorial Health System, our partner in Columbia and Greene counties, has been awarded two NYSDOH grants through Essential Health Care Provider Support Program (EHCPSP-I) and Capital Restructuring Finance Program (CRFP) to support expansion of primary care services across the two counties. They have taken steps to address the primary care physician shortages in their high-needs areas by:

- Recruiting a Family Medicine Physician for their Jefferson Heights site.
- Hiring an internist to work 2 days/ week in Hudson.
- Hiring a NP for the Valatie practice.

CapitalCare Medical Group hired 2 providers in 2016 to support 2 practices with high Medicaid populations.

Alignment of CPC+ with DSRIP

The goals for CPC+ have strong synergy with the goals of DSRIP. The required practice transformation aligns with the PCMH Level 3, and NYS APC. Ultimately these programs seek to increase quality and reduce costs by increasing the comprehensiveness of care based on the needs of a practice population. There are necessary care management enhancements that must be implemented for CPC+ that will ultimately facilitate the care management of the patient population for DSRIP. Identification of overlapping utilization and quality measures from these two initiatives has been beneficial in streamlining efforts for earning the maximum amount of incentives. Several of our partner organizations, including Albany Medical Center, Columbia Memorial Health, Saratoga Hospital System, CapitalCare Medical Group and Community Care Physicians, have been selected to participate in CPC+ since January 2017.

<u>Expansion of Primary Care Services – Activities in the Planning Phase:</u>

Albany Medical Center Hospital, lead entity for the AMCH PPS, has submitted an application on behalf of the AMCH PPS, in collaboration with Community Care Physicians PC, to procure funds through the Statewide Health Care Facility Transformation Program to expand primary care capacity in high-needs areas of Albany County. The award announcement is forthcoming.

The purpose of the project is to provide capital funding support through AMCH to facilitate expanded access to primary care services by creating 2 new clinical sites in hot spot neighborhoods as well as one site dedicated solely to meet the needs of pediatric patients. These service locations will be constructed or renovated by AMCH. The rapid access pediatric site will be staffed by the Medical College's Faculty Physician's Practice, where they will be integrated into the existing provider network and delivery system. The two free-standing outpatient clinics will be created in two of the following hot spot, underserved neighborhoods: Albany's South End and West Hill neighborhoods and the City of Cohoes. The pediatric rapid access site will be constructed on AMC's main campus in the South Park neighborhood and will be limited to the region's pediatric patients.

The overall strategy used to develop the Project Plan included in this section was based on work efforts conducted in support of DSRIP as well as strategic input from the executive leadership team at AMCH. The

Plan is a collaborative effort between Community Care Physicians (CCP) and AMCH, bringing the organizational strengths of the two organizations together in synergistic ways. The Plan is consistent with the institutional strategic plan developed by Albany Med, particularly as it relates to refining the primary care strategy, focusing recruitment on additional adult and pediatric primary care practitioners and investing in the communities most in need. As a teaching institution, it is also consistent with the mission of the Medical College to train tomorrow's medical professionals in a variety of settings. It will create a new cadre of trained professionals who understand the importance and value of working in a patient-centered medical home environment.

Albany Medical College Faculty Practice, another large multi-specialty hospital-based group is looking to several strategies, which include the addition of new providers within existing practices, acquisition of existing primary care practices into the larger organization, relocation and enlargement of existing practices, and the development of a hybrid PCP/Urgent care site located in the identified urban catchment areas. There are also plans for the development of a Transitional Care Clinic which would direct discharged patients through a clinic staffed by Advanced Primary Care practitioners (NP, PA). This model (re)directs discharged patients through a transitional pathway in the interim of hospital and PCP visit within the time frame instructed by the hospital or ED discharge. This helps to fill gaps so that patients may be seen in a timelier manner for appropriate evaluation and receive care coordination services to support their care.

Center for Disability Services is planning to introduce 'Open Access' to enhance access to primary care services for their at-risk members.

Columbia Memorial Health System, our partner in Columbia and Greene counties, has been awarded two NYSDOH grants through Essential Health Care Provider Support Program (EHCPSP-I) and Capital Restructuring Finance Program (CRFP) to support expansion of primary care services across the two counties. Specifically, they plan to address the primary care physician shortages in their high-needs areas by:

- Recruiting a PCP for a site in Greene County.
- Development of a 5-year plan for a large Primary Care Office in Hudson that will merge two existing offices plus add space for 4 additional FTEs, a clinic for the noncompliant and walk-in services to help decompress the ER.

Harmony Mills Pediatrics, a privately owned practice located in a hotspot ZIP code has submitted a proposal to the PMO requesting funds to support the addition of a second pediatrician to expand hours for two evenings per week and Saturdays.

Three of our Behavioral Health partners, **Albany County Department of Mental Health, Addiction Care Center of Albany, and Northern Rivers Family of Services** are planning to embed primary care services within their existing BH facilities to address many unmet medical needs of their clients.

Saratoga Hospital System is currently assessing their primary care physician needs and plans to bring on two (2) additional FT Primary Care MDs in 2017 while looking to fill a handful of advanced clinician roles as they roll out "Team Pod Approach" in their existing practice locations.

Koinonia Primary Care, located in a hotspot neighborhood, aims to do as much as possible under one roof for their patients; they face limitations with available resources, especially in the staffing of their providers. They have identified a number of opportunities for extending services not just at their site, but throughout the community where space could be utilized at little to no cost. Koinonia is recruiting another PCP to expand access.

CapitalCare Medical Group is expanding the care team to include LCSW and clinical pharmacist.

<u>Expansion of Primary Care Services – Plans for Future Consideration:</u>

With the goal of enhancing access to timely and effective primary care services to the attributed members,

AMCH PPS, in collaboration with participating partners and relevant PPS governing committees, will continue to evaluate the feasibility of implementing one or more of the following approaches:

- The development and implementation of a retention and recruitment fund supported by WorkForce efforts to assist practices in addressing access to primary care which will help to support financial incentives for new physicians and non-physician practitioners to join existing safety-net primary care organizations.
- Financial and other appropriate support for partnering organizations with their efforts to expand primary care access in high-need areas of Albany County. Specifically, the three ZIP codes; 12202, 12206, and 12047, with the large numbers of attributed members and limited primary care capacity, will be the initial areas of focus.

Expansion of Primary Care Services – Best Practices Identified within PCP Partners:

AMCH PPS has adopted and promoted a strategy aimed at addressing both capacity and access issues through the provision of walk-in blood pressure checks with a staff member other than the PCP. Koinonia Primary Care has been providing walk-in blood pressure checks to community members during the hours of 10-4, Monday through Friday (community members are defined as both established Koinonia patients and non-patients.) Those who present themselves to the clinic and request blood pressure screening will be accommodated. Koinonia nurses will take blood pressures according to best practice standardized technique as determined by best practices as approved by the AMCH PPS.

Koinonia's walk-in blood pressure policy and procedure has been presented to partners and is being piloted at other sites. The AMCH PPS PMO also created a template policy and procedure using elements from Koinonia as well as the Million Hearts Campaign. Enhancing access to blood pressure screenings through an open-access model is rapidly being adopted by our partners across the PPS. Albany Medical College Faculty Practice, Albany Family Medicine, a division of Community Care PC, and our regional partners at Columbia Memorial Hospital have adopted this policy and procedure. Albany Family Medicine planned to pilot this process at their site in September, and all applicable staff was trained as appropriate. As noted above, Whitney Young has also implemented a RN Care Coordinator to provide blood pressure checks to walk-in patients.

Clinical governance: Engaging Community-based and Institution-based PCPs:

As will be seen throughout this Primary Care Plan, clinical governance is vitally important and is the focus of the AMCH PPS Clinical & Quality Affairs Committee (CQAC), and the underlying Project-specific Subcommittees. CQAC draws upon the expertise of the AMC Faculty Group Practice's Clinical Quality Committee and the medical directors of the two largest primary care groups in the region, CapitalCare Medical Group and Community Care Physicians. Committees and subcommittees include representation from institution-based PCPs and community-based PCPs. The AMCH PPS has also developed a Primary Care Advisory Group to ensure continued engagement of PCPs. AMCH PPS recognizes the need to provide various incentives, support for PCMH transformation/ expansion, community-based care coordination, access to specialists, linkages for transitions of care, and enhancing technical capabilities/ usage. The subsequent sections of this Primary Care Plan will elaborate further on AMCH's plans for preparing and supporting the primary care partners through the changes that will be required for, and a result of, meeting the expectations and deliverables associated with DSRIP.

How will primary care expansion and practice and workforce transformation be supported with training and technical assistance?

- **What are your PPS's plans for working with Primary Care at the practice level, and how are you supporting them to successfully achieve PCMH/APC?**
  - **Resources could include collaboration, accreditation, incentives, training/staffing support, practice transformation support, central resources, vendors to support key activities, additional staffing resources, etc.**
- **How is your PPS working to ensure that existing statewide resources for technical assistance are being leveraged appropriately?**

Primary care expansion is imperative to truly gain successful transformation. The AMCH PPS is committed to the expansion of Primary Care through assisting and supporting its practices with NCQA Patient Centered Medical Home (PCMH) Level 3 2014 transformation or the Advanced Primary Care (APC) Initiative. PCMH is seen as the bedrock of DSRIP's success as it is cross cutting to many of the project deliverables, and focuses on the shared goal of the quadruple aim; improving clinical outcomes, enhancing the patient experience, increasing provider and staff satisfaction, while reducing the number per capita cost.

Activities that have been implemented:

In January 2016, the PPS performed a current-state assessment of all primary care partners to better understand the practices' PCMH recognition status, provider make up, Medicaid volumes, EMR capabilities, and both prior and intended Meaningful Use attestation. We also sought to learn about our partners' driving motivations for becoming NCQA recognized, along with their actual or perceived operational, technical, and financial barriers to achieving the recognition. We discovered a divergent landscape across the region comprised of practices who had never applied for PCMH recognition, those who were either recognized as NCQA Level 3 PCMHs under the 2011 standards or on their way to being recognized as Level 3 PCMH under the 2014 standards and everything in between. At the time of assessment, fewer than 50% of our 78 practices had current NCQA recognition. Since the assessment, fifteen practice sites have earned recognition as Level 3 PCMH under the 2014 standards and several others are in the process of pursuing this achievement. To our benefit, all practices reported having a CEHRT with capabilities for bi-directional connectivity with the local RHIO, Hixny (Health Information Xchange of NY.) That said, it was reported that only 61% of providers would be attesting for Meaningful Use 2015, giving us some opportunity for improvement in the current year.

We learned that practices are eager to earn PCMH recognition for all the right reasons: they want to provide better coordinated care in a team environment, enhancing the outcomes and experience for patients; they want to identify and assist high risk patients in getting the care and community connections they need; they want to engage their patients in a partnership to keep them well. Many practices, however, cited the same barriers to transformation, most notably the need for more financial and human resources to manage the application process and the ongoing monitoring needed to maintain true practice transformation. Many practices also stated a need for technical assistance around EHR functionality like building templates, automating reports, and technical assistance with the NCQA application.

Organization	Practice/Site	No. PCPs @ site	Sites w/2011 recognition	Sites w/ 2014 recognition	Sites w/no recognition
Albany Medical Center	5	41	4	N/A	1
Capital Care	23	111	18	N/A	5
Center for Disability Services	1	2	N/A	1	N/A
Columbia Memorial Hospital	15	41	2	11	2
Community Care PC	19	135	N/A	N/A	19
Koinonia Primary Care	1	3	N/A	N/A	1
Harmony Mills	1	2	N/A	N/A	1
Riverview Pediatrics	1	3	N/A	N/A	1
Saratoga Hospital	9	50	N/A	1	8
Shaker Pediatrics	1	6	N/A	N/A	1
Whitney M. Young Health Center	2	12	N/A	2	N/A
	78	406	24	15	39

**Primary Care Practice data from January 2016; PCMH recognition data as of February 2017*

A clinical manager was hired in DY1 to support the primary care practices on their transformation endeavors as well as to assist the PPS with sustainability after PCMH recognition is achieved. As a first step in the journey to become content expert certified, the manager attended two NCQA PCMH trainings, Introduction to PCMH: Foundational Concepts of the Medical Home and Advanced PCMH: Mastering the Medical Home Transformation. Upon returning from NCQA training, the manager presented a training session in an effort to inform the project management staff on the fundamentals of the medical home. Because PCMH recognition is a requirement of six DSRIP projects, we felt it important for the PMO to understand the complexities of the PCMH and their relationship to project specific DSRIP objectives.

In April 2016, under the auspice of the CQAC, the first meeting of the Primary Care Advisory Group was held. The purpose of this work group formation is to promote active primary care participation in DSRIP projects, facilitate and promote PCMH recognition and the adoption of standards in primary care, promote integration of primary care and behavioral health, assist the PPS in determining current primary care capacity, performance needs and developing a plan for those needs, and lastly to facilitate primary care participation in the development of value based payment models. During the first work group meeting, we assessed our partner's readiness or current standing in their PCMH efforts along with any barriers or challenges they faced in successful implementation. As a follow up to the initial meeting of the Primary care Advisory Group, a secondary questionnaire was developed and disseminated to assess what level of support each practice felt they would need in order to develop an appropriate RFP.

As an initial support strategy, in early July 2016, AMCH PPS supported more than 30 clinical and administrative leaders from participating organizations to attend the two-day training in Saratoga Springs, NY which was hosted by HANYS and sponsored by the PPS' Workforce Coordinating Council. The course, "Primary Care Practice Transformation-People, Processes, and Technology" addressed not just the fundamentals of the PCMH framework, but also concepts around how to create meaningful and sustainable transformation within the primary care practice setting. Valuable feedback was provided by our partners

indicating needs from their perspective which we have taken into consideration as the PPS determined an appropriate course of action for PCMH transformation.

Based on the information collected in both assessments, as well as the feedback provided after the HANYS learning collaborative, the AMCH PPS has launched efforts to engage a vendor to support true practice transformation in order to create a sustainable primary care network that supports the efforts of DSRIP. In September 2016, the PMO sent out a request for information to five potential PCMH vendors. Four of the five responded to our request; Primary Care Development Corporation (PCDC), ECG Management Consultants, Health Care Association of NYS (HANYS), and CDPHP. Vendor demonstrations were held during the month of October. In November 2016, the PPS distributed an RFP for PCMH Readiness Assessment and Implementation to the above listed vendors. An objective review committee was formed comprised of representation from the Primary Care Advisory Group as well as PMO leadership in order to fairly evaluate the RFP responses. In January 2017 after approval from the PPS Finance Committee and Board of Directors, HANYS was chosen as the vendor to support the PPS in its transformation efforts. Additionally, in December 2016, HANYS was awarded a technical assistance contract with New York State to partner with primary care practices across the state and guide them through the transformation to Advanced Primary Care (APC). The APC framework, which is based on the principles of PCMH and CPCI model, will be used to support practices in the transition to value based payment arrangements**.**

Additionally, the PPS in collaboration with Accenture LLP developed a comprehensive Clinical Integration Strategy Care Coordination Model (CICCM) in an effort to support Primary Care expansion. This strategy includes the standardization of the ED/observation processes, transitions of care processes, readmission management, risk identification/stratification, and the standardization of clinical and supporting information exchanged at care transitions across the continuum, all key functions for strengthening the primary care system. The PMO has held several in depth trainings on the CI CCM for key clinical and administrative staff from our partnering organizations. Comprehensive care management and care coordination is a fundamental function of an effective PCMH; therefore training on the CICCM is vital for primary care practices.

Current Activities:

At present, HANYS is in the process of working in collaboration with AMCH PMO and our primary care partners to better understand the practice breakdown, partners and organizations as well as key individuals to ensure a successful engagement. During this initial phase, HANYS will also be assisting partners to determine if PCMH, APC or a combination of both is the most appropriate path for the organization to take in order to begin transformation efforts.

Planned Future Activities:

Several key support strategies will be leveraged during the HANYS PCMH engagement. The PPS has defined two specific areas of support in the RFP called Tier I and Tier II. In Tier I, The AMCH PPS PMO will provide an opportunity for each of the partnering organizations to choose one site within their organizations, with the highest Medicaid lives, that would be interested in participating in one to one training. In total, there will potentially be 9 practice sites that will need 1:1 training. In Tier II, the PPS is providing all 11 organizations an opportunity to participate in the group training/learning collaboratives. This could be up to 78 participating primary care sites in total.

During the project planning phase, HANYS will be assessing practice readiness by way of in person baseline

assessment for all Tier I practices. Following this assessment, HANYS will determine a gap analysis and any identified risks in order to close gaps throughout the engagement. During the Tier I engagement, HANYS will provide scheduled web based interactive advisory sessions, a client learning platform with required learning modules to be completed by the practice, policy and procedure templates, as well as personalized support from a PCMH advisor for task management throughout the transformation at the practice level. Additionally, HANYS will be providing a "train the trainer" approach whereby the PCMH advisor will work with a practice level facilitator to complete training with the practice during staff meetings. This will also assist with sustainability efforts after recognition is achieved.

For Tier II practices, HANYS will offer in person learning collaboratives to 78 practice sites whereby key clinical and administrative leaders will attend. These sessions will be broken into 2 groups to ensure small group interaction. HANYS will provide one in person 3 hour learning collaboratives with one facilitator on a quarterly basis until the completion of the engagement. All sessions are focused on the NCQA standards well as other key topics such as auditing, submission and documentation requirements.

A core component to successful maintenance of NCQA PCMH Level recognition is a robust sustainability plan, and HANYS has woven into every aspect of the practice engagement and communication. HANYS will be working with the clinical manager to assure sustainability post engagement. The clinical manager for the PPS will also be available during the engagement to offer basic technical support and respond to inquiries that practices may have or to serve as a liaison between practices and the vendor or NCQA.

Utilizing the Care Coordination Care Management (CCCM) Model developed in collaboration with Accenture and 26 PPS partners as a framework, the AMCH PPS is also developing a comprehensive CCCM program known as BHNNY Cares working with downstream health home care management agencies, PCMHs and other relevant CBOs to strengthen and expand capabilities of our primary care partners. BHNNY cares aims to identify, engage, and link eligible attributed members (health home eligible, or higher risk members not currently eligible for health homes) to appropriate CCCM resources. BHNNY Cares has defined roles for Primary Care partners that include :

- Achieve **NCQA 2014 PCMH** or **NYS Advance Primary Care (APC) – Gate 2** recognition by December, 2017.
- If currently a NCQA recognized PCMH on 2014 standards, sustain systems & processes essential for ongoing adherence to "Must-Pass" standards and "Critical" elements.
- Embedding on-site BH services by participating in Integration of Primary Care and Behavioral Health services project (3.a.i) **or** establish partnerships with community-based BH organizations for referral and care coordination
- Implement systems to proactively identify patients in need of care coordination and care management services that require referral to external CCCM entities.
- Identify patients eligible for NYSDOH Health Home services and refer to an appropriate agency. Develop or strengthen collaboration with Central CCCM, HH CMAs, and other community-based CCCM entities.
- Identify a practice-based liaison to work directly with the Central CCCM and HH CMAs regarding referrals, enrollment status, and patient updates to care.
- Develop processes to review, update, and share care plans as appropriate.
- Facilitate ongoing case reviews with care management teams to discuss issues related to managing high-risk members.
- Develop processes to maximize the utilization of available IT resources for timely interventions.

BHNNY Cares applies population health concepts such as risk stratification; goals for the care team, patient, and system; appropriate and intentional care teams who are activated based on the identified needs of the patient(s).

Additionally, the AMCH PPS is in the early planning stages of implementing a recruitment and retention fund modeled after the strategy implemented by AHI PPS. This retention and recruitment fund is intended to support participating providers in addressing access to primary care in an effort to transform health care within the AMCH PPS five county catchment area. It is the intent of the lead agency as part of the PPS' workforce strategy, to recruit and retain primary care practitioners to expand access to primary care services. All prospective organizations would need to apply for the retention and recruitment funds and show specific alignment with DSRIP projects in order to be considered. To maintain a fair and consistent process, the PPS will form a retention and recruitment objective review committee comprised of representation from the Clinical and Quality Affairs Committee (CQAC), Workforce Coordinating Council (WCC), and applicable PPS leadership. All applications will be submitted to the committee for objective review and consideration of the candidate. The retention and recruitment fund plan will be going before the PPS Finance Committee and Board of Directors for formal approval.

Leveraging Statewide Resources

The Medicaid Analytics Performance Portal (MAPP) remains very much an integral tool for the PMO's Data Team. Pairing the information that can be extracted from Salient and/or MAPP with the NYS DOH Medicaid claims database (in accordance with the SSP Workbooks) provides the PMO with a well-versed macro-perspective of the progress being made towards improving the primary care objectives. Furthermore, Hixny and Statewide Health Information Network for New York (SHIN-NY) are being utilized to provide linkages among numerous organizations as well as to serve as a platform for various project needs and deliverables such as connectivity, real time alerts, sharing of care plans, and registries. Lastly, the PPS is finalizing plans to implement the SpectraMedix platform, a solution which will leverage numerous data sources such as the Claims database, partner clinical and pre-adjudicated claims data, and the Hixny community health record to provide retrospective and predictive analytics specific to the PPS network. The 360 Platform will help to facilitate the transition to pay for performance and risk-based models with solutions for advanced data integration, measures calculation and regulatory reporting, and predictive modeling and at-risk patient surveillance applied to a range of performance initiatives from patient level to population level.

In addition to leveraging analytic resources, the AMCH PPS recognizes the importance of augmenting regional and national population health initiatives. Million Hearts is a national initiative to prevent one million heart attacks and strokes by 2017. Prior to DSRIP, two of the AMCH PPS' partners, The Albany County Health Department and Whitney M. Young Jr. Health Center, took part in this NYSDOH led statewide initiative working with the CDC and ASTHO. As a PPS, we are highlighting the experiences from these partners as a demonstration of best practices to support our primary care practices with the implementation of the Million Hearts tools and framework into their respective organizations.

The AMCH PPS also leverages its close connection with the Asthma Coalition of the Capital Region (ACCR). ACCR is one of eight Regional Asthma Coalitions in NYS that receives funding specifically to implement interventions in communities with high rates of asthma hospitalizations and ED visits. ACCR's mission is to coordinate sustainable initiatives that will reduce the burden of asthma in NY's Capital Region. ACCR worked closely with AMCH PPS Leadership during the DSRIP application process, and continues to be involved with the PPS and the Asthma Project Subcommittee. The AMCH PPS Medical Director is also ACCR's Physician

Director, and the lead/ fiscal agency of ACCR is a PPS partner. Furthermore, many PPS PCPs in the asthma project are also participating with ACCR. The PPS has an opportunity to scale up on the activities/ projects of ACCR to support implementation of evidence-based guidelines for managing asthma in the primary care setting, as well as enhancing the clinical-community linkages.

What is the PPS's strategy for how primary care will play a central role in an integrated delivery system?

- **How will the PPS strengthen the continuum of Primary Care and ensure meaningful linkages to necessary secondary and tertiary services?**
- **How is Primary Care represented in your PPS's governance committees and structure and clinical quality committees?**

Primary care is essential in improving patient health and providing equitable access to health care. The AMCH PPS recognizes that a seamless linkage between episodic care, such as hospital inpatient and emergent care services, and primary care is critical to ensure a full continuum of care for our patients. Therefore, utilizing the following strategies, we will strive to assure that primary care physicians (PCPs) are key players who orchestrate other members of the integrated delivery system (IDS).

Activities that have been implemented:

Adoption of Clinical Integration/Care Coordination Model

The AMCH PPS has developed a Clinical Integration/Care Coordination Model (CI/CCM) that fully describes the future state in which PCPs play a central role. Under this model, community-based primary care is a critical component of the cyclical continuum of care coordination from acute to community settings. To date, the AMCH PPS has adopted various parts of this model, including training on CI/CCM offered to clinical and administrative staff, improvement of HIXNY connectivity and placement of care coordinators in various clinical settings such as EDs and PCP offices.

Training on CI/CCM for Clinical and Administrative Staff

In September 2016, the AMCH PPS has hosted CI/CCM Overview training to introduce care coordination model framework with its elements, processes, functions and protocols. The training also explained transitions of care in the community and ED patient navigator processes.

Improvements in HIXNY Connectivity

Efficient electronic communication between providers is critical for successful implementation of the CI/CCM. In addition, enhanced HIXNY connectivity ensures meaningful linkages between PCPs and other regional providers with timely communications and information sharing. To date, all contracted PCPs have connected to HIXNY and actively share data with many of them have subscribed to alerts.

Placement of Care Coordinators

As part of the ED Care Triage project, patient navigator functions have been implemented within the three EDs in our PPS region. Furthermore, the AMCH PPS has aligned incentives to support the functions, including care coordination, care management, and linkages to community resources.

Emphasis on Linkages to Health Homes and Behavioral Health Providers under DSRIP Projects

The AMCH PPS is working with other PPS partners, such as behavioral health providers and Health Home agencies, for various DSRIP projects to encourage improved linkages to their local PCPs/PCMHs. As listed below, PCPs are represented in almost all project subcommittees that meet on a monthly basis. By working directly with primary care practices and other secondary and tertiary service providers, the AMCH PPS acts as a liaison and foster relationships between providers who often did not collaborate prior to DSRIP.

Primary Care Representation in the AMCH PPS Governance Structure

The AMCH PPS's governance structure reflects how primary care is involved in the decision-making processes. The Project Advisory Committee (PAC) Leadership Committee, which consists of representatives of the 10 largest providers of Medicaid services in our PPS and chairs of workstream committees, have

several PCPs as voting members. In addition, the CQAC consists of PCPs and clinical leaders from various partner organizations, all of whom provide valuable input and guidance regarding the PPS's direction for supporting primary care system. Six project-specific subcommittees, including the ED Care Triage, Health Home At-Risk Intervention, Asthma, Cardiovascular, Primary Care/Behavioral Health Integration, and Community-Based Crisis Stabilization Project Subcommittees, were established to engage practitioners, including PCPs, who regularly meet and discuss the implementation of our DSRIP projects.

In addition to the governance structure that includes PCPs, the Primary Care Advisory Group was established in August 2016 to create another avenue for PCPs to become involved in our PPS activities. This advisory group consists of PCPs from institutional-based and community-based practices that provide insight and expertise on DSRIP initiatives related to strengthening the primary care system. This group will continue to meet on a regular basis to offer guidance and input on the AMCH PPS's project implementation and transformational efforts.

Our largest participating primary care organizations are well represented by primary care providers on the CQAC (governance committee) and the underlying project subcommittees reporting up to the CQAC:

Governance Committee/ Project Subcommittee	Name and Title	Organization
PAC Leadership Group	Ronald Pope, DO, Dir. of Ambulatory Care Network	Columbia Memorial Hospital
PAC Leadership Group	George Davis, MD, Family Medicine Physician Representative	Columbia Memorial Hospital
PAC Leadership Group	Neil Mitnick, MD, Family Medicine Physician	Albany Family Medicine at Community Care PC
Clinical & Quality Affairs	Carrin Schottler-Thal, MD, Section Head, Div. of General Pediatrics	Albany Medical Center
Clinical & Quality Affairs	Kallanna Manjunath, MD, CMO	AMCH PPS
Clinical & Quality Affairs	Paul Sorum, MD, Assoc. Professor, Peds and Internal Medicine	Albany Medical Center
Clinical & Quality Affairs	Ronald Pope, DO, Dir. of Ambulatory Care Network	Columbia Memorial Hospital
Clinical & Quality Affairs	George Davis, MD, Family Medicine Physician Representative	Columbia Memorial Hospital
Clinical & Quality Affairs	Maria Kansas Devine, MD, Medical Director	Center for Disability Services
Clinical & Quality Affairs	Sean Roche, MD, Medical Director	Albany Family Medicine at Community Care PC
HHAR	Kallanna Manjunath, MD, CMO	AMCH PPS
HHAR	Ronald Pope, DO, Medical Director	Columbia Memorial Hospital
HHAR	Ted Zeltner, MD	Whitney Young Health Center
3.a.i	Bob Paeglow, MD	Koinonia Primary Care
3.a.i	Henry Neilley, MD	Shaker Pediatrics
3.a.i	John Rosenberger, MD	Albany Medical Center Internal Medicine

3.a.i	Kallanna Manjunath, MD, CMO	AMCH PPS
3.a.i	Mary Kathleen DiTursi, MD	Harmony Mills Pediatrics
3.a.i	Renee Rodriguez-Goodemote, MD, Medical Director	Saratoga Community Health Center
3.a.i	Ronald Pope, DO, Medical Director	Columbia Memorial Hospital
3.a.i	Maria Kansas Devine, MD, Medical Director	Center for Disability Services
3.a.ii	Kallanna Manjunath, MD, CMO	AMCH PPS
3.a.ii	Maria Kansas Devine, MD, Medical Director	Center for Disability Services
CVD	Bob Paeglow, MD	Koinonia Primary Care
CVD	Joseph Wayne, MD	Albany Medical Center Faculty Practice
CVD	Kallanna Manjunath, MD, CMO	AMCH PPS
CVD	Lawrence Perl, MD, Chief Medical Officer	Columbia Memorial Hospital
CVD	Lawrence Robinson, MD	Albany Medical Center Faculty Practice
CVD	Maria Kansas Devine, MD, Medical Director	Center for Disability Services
CVD	Paul Lemanski, MD	CapitalCare Medical Group
CVD	Paul Sorum, MD	Albany Medical Center Faculty Practice
CVD	Ronald Pope, DO, Medical Director	Columbia Memorial Hospital
CVD	Sean Roche, MD	Albany Family Medicine at Community Care PC
CVD	William Murphy, MD	Columbia Memorial Hospital
Asthma	Christine Lee, MD	Columbia Memorial Hospital
Asthma	Gina Nickels-Nelson, NP	Albany Medical Center General Pediatric Group
Asthma	Henry Neilley, MD	Shaker Pediatrics
Asthma	Kallanna Manjunath, MD, CMO	AMCH PPS
Asthma	Lawrence Robinson, MD	Albany Medical Center Faculty Practice
Asthma	Mary Kathleen DiTursi, MD	Harmony Mills Pediatrics
Asthma	Nancy Getzke, NP	Columbia Memorial Hospital
Asthma	Stephen De Waal Malefyt, MD	Albany Medical Center General Pediatric Group
Asthma	Vishalakshi Sundaram, MD	Albany Family Medicine at Community Care PC

What is the PPS's strategy to enable primary care to participate effectively in value-based payments?

- **How will key issues for shifting to VBP be managed? (e.g., technical assistance on contracting and data analysis, ensuring primary care providers receive necessary data from hospitals/emergency departments (EDs), creating transition plans, addressing workforce needs and behavioral health integration)**

The PPS recognizes the importance of providing education to facilitate the transition to value-based payment (VBP) arrangements, as well as the necessity of PCP involvement. The PPS has taken numerous steps towards this education, all of which help manage the issues related to the evolution to a VBP structure.

The PPS formed a VBP workgroup that has met monthly since April 2016. The membership includes four MCOs and twelve partner organizations, half of which are primary care providers. The primary charge of the workgroup is to provide education and guidance to partner organizations and to collaboratively create a VBP roadmap.

The PMO conducted a comprehensive baseline survey in the fall of 2015 that included several questions related to VBP. The PMO, in collaboration with the VBP workgroup, facilitated a more focused assessment in the fall of 2016 that surveyed all funded partners about current state of VBP contracts, education and technical/data needs, perceived barriers to success, and preferred VBP compensation modalities. This information was used to obtain an updated current state, defined learning and technical needs, and is assisting with the development of the PPS-specific VBP educational series.

The PPS had several organizations represented at the Region 1 VBP boot camps hosted by the State in June and July 2016. Additionally, the PMO has provided the link to the recordings to the PPS network and encouraged all partners to view the sessions. An in-depth recap of each boot camp was provided at both the VBP workgroup and PAC monthly meetings. Discussion ensued as to gaps remaining post boot camp. As a result, the PMO is in the process of planning a PPS wide learning collaborative. Based on feedback from the VBP workgroup members, it was determined that organizations with robust experience with VBP arrangements should be recruited to present on real-life examples and to provide feedback on the process of their transition. Additionally, the PMO has reached out to the Department of Health to inquire about State representation at the learning collaborative to answer PPS-specific questions regarding the transition to VBP in our five-county region.

To help incentivize partners to transition to VBP, the PPS has contracted COPE Health Solutions to assist in the funds flow and partner contracting process, which delineates project involvement and contract deliverables for each individual project. The second phase of partner contracting, which began in January 2017, is largely focused on processes to transition the applicable PPS entities towards value-based purchasing along with other essential components needed for successful health system transformation.

The PPS developed a Target Workforce State Report in collaboration with BDO Consulting and their partner Iroquois Healthcare Association, Inc. (IHA). This report identifies the projected workforce needs of the PPS through the end of DSRIP Demonstration Year 5 (2020). These projected needs were determined through IHA's microsimulation model and were based on current state input provided by the PPS that included information about workforce, patient volumes by payer, and models of care, along with data-driven project planning assumptions, including anticipated staffing models and caseload ratios, many of which were forecasted through the Clinical Integration project led by the consulting firm Accenture.

In order to increase participating providers' interest in providing integrated/ co-located substance abuse treatment, the PMO has provided education via webinar to executive leadership at participating organizations regarding the regional need for substance abuse treatment and the benefits for co-location of such treatment. Moreover, the PMO has had ongoing conversations with participating providers both individually and within Project 3.a.i Subcommittee meetings to support participation in this aspect of Project 3.a.i, and to proactively address any barriers to implementation. Presently, a number of participating providers have expressed interest in ultimately providing treatment for substance abuse disorders after they develop or expand their abilities to provide co-located/integrated mental health and primary care services. The PMO has provided education to address participating providers' questions and concerns regarding how to provide integrated services without exceeding their respective licensure thresholds.

How does your PPS's funds flow support your Primary Care strategies?

- **What resources are being expended by your PPS to support PCPs in DSRIP?**

The PPS, in collaboration with COPE Health Solutions, has created a funds flow methodology that supports the PPS network, specifically Primary Care. Over the course of the first phase of this contracting process, which covers 4/1/2015-12/31/2016, refined deliverables were created that range from project or work stream specific, to reporting or engagement. The funds are allocated based on provider type, project participation, and attributed lives. Approximately 20% of AMCH PPS's partner organizations have a PCP designation, and almost 60% of the PPS's attributed lives are credited to these organizations. $9.7 million was allocated to partner organizations during the first phase of contracting as described above. Primary Care providers represent over 77% of this allocation. As of February 2017, over $5.6 million dollars in total has been distributed to partner organizations from the first phase of contracting. Approximately $4.7 million of the total dollars funded was to organizations that offer primary care. The PMO is actively working with partners to complete several deliverables that will yield an additional $3-4 million in distributions.

Phase I (4/1/2015-12/31/2016) Funds Flow Strategy Review

Several of the contract deliverables in the first phase of contracting were created to incentivize Primary Care providers, including participation in a PCMH learning collaborative, completion of various project-specific registries and patient engagement data, an updated comprehensive baseline assessment, collaboration with Health Homes and EDs, policies and procedures on a wide array of topics (warm referrals, blood pressure checks, Behavioral Health screenings, crisis referrals, medication regimen simplification), as well as adoption of several best practice guidelines.

Phase II (1/1/2017-3/31/2018) Funds Flow Strategy

AMCH PPS has allocated $13 million to all partner organizations for the second phase of contracting, which covers a term of 1/1/2017-3/31/2018. Approximately 85% of the funds have been allocated to partners that offer primary care services. Contrary to the first phase of contracting, the development of these contracts was a coordinated effort between the PMO, COPE Health Solutions, and several partner organizations. Draft metrics were brought to various committees for their feedback. This process helped ensure the metrics were developed by the clinicians in the network and helped AMCH PPS obtain buy-in from the partner organizations.

This phase focuses not only on performance activities, such as policy and procedure development, meeting participation, and patient engagement/registries, but also includes several metrics specific to the required outcome measures. Similar to how DSRIP is structured, the partners will receive funding for outcome measures when the PPS achieves their performance goals. The contracts are expected to be released for

execution by 3/10/2017.

It is anticipated that the third phase of contracting will include predominantly outcome measure metrics to ensure that the PPS network is actively working toward the end goal of providing better patient care, reducing unnecessary ED visits and inpatient readmissions, and increasing population health.

Vendor Contracting

The PPS is in the process of contracting with a vendor to assist the network with care coordination. This arrangement will assist our Primary Care partners with organizing patient care activities and result in more effective care.

AMCH PPS recognizes that transforming primary care practices toward PCMH or APC is critical to the success of the DSRIP initiative. Through a formal RFP process and objective review committee, the PPS has chosen HANYS PCMH Advisory Services as the consultant to support the PPS with transformation efforts. As part of this engagement, the PPS will provide Tier One (one to one support for up to 9 practice sites) and Tier II (learning collaboratives for up to 78 practice sites) funding support to our primary care partners.

How is the PPS progressing toward integrating Primary Care and Behavioral Health (building beyond what is reported for Project 3.a.i)?

- **This would include both collaborative care and the development of needed community-based providers.**

The AMCH PPS is progressing well toward integrating primary care and behavioral health services, a key element of our primary care plan. We have demonstrated a methodical and comprehensive approach to planning and beginning to implement such service integration across the life of AMCH PPS. Below, we first highlight what we have done already in regards to this goal. Next, we discuss our plans related to such integration moving forward. Much of the success of integrating Primary Care and Behavioral Health is predicated on the availability of behavioral health providers, primary care providers, and case managers/care coordinators. To that end, it is vital that we identify PPS needs, develop and implement a strategy to support the development of needed providers, and identify and engage existing providers available for integration.

Previously Achieved/Implemented Activities

Need for Integrated Services

Those managing serious mental illnesses often encounter significantly higher prevalence of severe comorbid conditions, including diabetes, obesity, high blood pressure, tobacco dependence, addictions and other issues that often shorten their life expectancy by decades. Behavioral health providers in our PPS serve a significant number of individuals at high risk for substantial medical need who continue to return to the EDs due to the lack of linkage to preventive medical care. According to the comprehensive current state assessment conducted in September 2015, numerous organizations in our PPS expressed great interest in integrating both primary care and behavioral health services at their current sites. In the Fall of 2016. We conducted a current state assessment of primary care and behavioral health organizations interested in participating in this project to obtain detailed information about their current capacity and processes, as well as specific needs identified for successful integration. Responses to this survey provided guidance to the PPS on tailoring DSRIP support and assistance to the needs of each organization.

Governance Structure

During the DSRIP application phase, the AMCH PMO convened a committee of key behavioral health

stakeholders, including executive leadership, clinicians, and content area experts from behavioral health organizations, local governmental organizations, and community organizations throughout our PPS. This group met regularly and, drawing from national and local best practices and findings, helped develop an application for Project 3.a.i that met the needs of the Medicaid beneficiaries attributed to AMCH PPS. To best meet regional needs, this group of stakeholders determined that the AMCH PPS should implement all three models of service integration.

In order to support the Project Subcommittee and workgroup activities, the AMCH PPS established an internal behavioral health team that consisted of executive leadership, licensed medical and behavioral health providers, and project management staff. This group works closely, and shares members, with each of the AMCH PPS groups integral to our Primary Care effort, including: the CQAC; the PCMH, Clinical Integration, and Practitioner Engagement workstreams; and the Primary Care Advisory Group. Such cooperation ensures that primary care and behavioral health integration is a fundamental aspect of our overall primary care effort, and ensures that our efforts to integrate these services are consistent with relevant PCMH standards.

The AMCH PPS then convened a Project 3.a.i Subcommittee under the auspices of the Clinical and Quality Affairs Committee. Co-chaired by the executive director of a prominent behavioral health organization and the AMCH PMO psychologist, the group consists primarily of executive leadership, clinicians, and content area experts from PPS primary care and behavioral health organizations, as well as representatives from managed care and community-based organizations.

To better support model-specific integration activities, two distinct workgroups were established under this project subcommittee; one focused on the primary care-based models of integration, and another focused on the behavioral health-based models of integration. Both workgroups consisted of primary care and behavioral health clinicians, leadership, and experts. Each member of the primary care-based workgroup has significant interest and/or experience integrating behavioral health services into primary care sites, and their expertise and support are fundamental to our primary care plan. These workgroups have previously reviewed model-specific guidance documents for service integration, which were subsequently disseminated to participating providers.

Next, the AMCH PPS convened a Behavioral Health Quality Improvement Subcommittee under the auspices of the Clinical and Quality Affairs Committee. The goals of this committee include supporting behavioral health quality improvement initiatives including those related to the integration of primary care and behavioral health services and increasing screening rates for depression. Members of the 3ai and 3aii project subcommittees along with representatives from partner health home Care Management agencies were invited to serve on this subcommittee, which includes medical and behavioral health providers.

Project Implementation Activities and Engagement of Partners

The PMO behavioral health team developed and presented two hour-long webinars to PPS partners to educate on the need for and benefits of co-located/integrated care and the AMCH PPS's three models of primary care and behavioral health service integration. Concurrently, key members of the AMCH PPS PMO's behavioral health team, including the Medical Director and Psychologist, met regularly with individual primary care and behavioral health stakeholders throughout our region. These meetings were aimed at educating partners on integration of primary care and behavioral health services, supporting partner participation in service integration, and early identification and mitigation of any identified risks and

barriers. During these meetings, several organizations have shown interest in furnishing primary care and behavioral health providers for integration into other organizations in our PPS.
Partners expressed interest and engagement in Model 3 (IMPACT/Collaborative Care Model) after the AMCH PPS provided additional training and education via a webinar to the PAC and the Project 3.a.i Subcommittee. Discussion regarding the particular benefits and elements of the IMPACT Model has been ongoing at the subcommittee, workgroup, and partner level. The AMCH PPS PMO behavioral health team has provided IMPACT/Collaborative Care guidance documents and resources to partners, workgroups, the 3.a.i Subcommittee, and primary care-related PPS partners as needed.

In addition to regular outreach and education of individual partners, the AMCH PPS sought the assistance of actively participating project subcommittee members in the development of a practice-specific current state assessment of readiness for service integration for participating organizations. The AMCH PPS also sought partner assistance regarding recommendations for preventative care behavioral health screening for depression, standards of care for the management of depression and ADHD in primary care settings, and the University of Washington's Advancing Integrated Mental Health Solutions (AIMS) Center's resources regarding IMPACT Model collaborative care standards. The recommendations for preventative care behavioral health depression screenings for adults and adolescents, and the evidence-based standards of care for management of depression and ADHD in primary care were subsequently approved by the CQAC. PPS-wide, many participating providers are already providing preventative care behavioral health screenings to patients. The Project 3ai Subcommittee also provided recommendations to the AMCH PPS Clinical Integration Workgroup regarding behavioral health screening questions in the future state model of clinical integration.

Much of the success of integrating Primary Care and Behavioral Health is predicated on the availability of providers. As such, we developed a strategy to support the development of needed providers. We distributed a comprehensive baseline assessment to all PPS partners, which assessed the type and number of behavioral health and primary care providers at each organization. We will conduct annual updates to this comprehensive baseline assessment. Moreover, we have analyzed the results of a detailed Practice Evaluation to participating organizations, which provided further information regarding the availability of, and need for, providers. As previously described, the AMCH PPS engaged a workforce consulting firm to conduct a compensation and benefits analysis in order to generate a Current State Workforce assessment, and also to project the Workforce Target State. Using the Current State and Target state, we performed a gap analysis, which was used to develop the Workforce Transition Roadmap. This Roadmap will serve as the guide for workforce development moving forward. Additionally, AMCH PPS has established a Workforce Coordinating Council consisting of HR representation from multiple stakeholders and provider types, union representation, and subject matter experts. This council serves as a PPS governance committee to oversee current and future state resource needs across the PPS, including community-based primary care and behavioral health providers. Finally, we are working with the Project 3.a.i Sub-committee and its constituent work-groups, and individual partner organizations to identify organizations able to furnish primary care and behavioral health providers for integration into other organizations. Thus far, we have identified a few organizations interested in doing so.

A number of our participating providers are well-along in integrating behavioral health services into primary care sites, and will continue to provide important guidance to our less-experienced partners. For example, Koinonia Primary Care, Albany Medical Center Pediatrics Group, Albany Medical Center's Internal Medicine Group, and Saratoga Community Health Center all provide integrated/co-located behavioral health services

within a primary care setting. Columbia Memorial Health system is working to integrate primary care with behavioral health and is currently investigating Tele-Health options to integrate with Psychiatry and Primary Care. Moreover, a number of our participating behavioral health providers are planning to integrate or co-locate primary care services into their sites, including our key partners the Addictions Care Center of Albany and the Capital District Psychiatric Center, who can serve as guides to our less-experienced partners as they integrate services. Other key partners include the three hospital systems within our region, Albany Medical Center, Saratoga Hospital, and Columbia Memorial Health. Furthermore, Columbia Memorial Health has received a Capital Restructuring Financing award for the development of comprehensive preventative and primary care treatment center with co-located behavioral health care. We are working closely to support the efforts of all of our partners, whether they are far along or just beginning the process of service integration.

Planned Future Activities

The AMCH PPS is working to meet a range of March project deliverables integral to the integration of primary care and behavioral health services, including the use of coordinated evidence-based standards of care, the use of EHRs with integrated medical and behavioral health records and which can track engaged patients, and the identification of depression care managers and consulting psychiatrist for the IMPACT/Collaborative Care Model of integrated care. Additionally, we have a number of planned future activities related to the integration of primary care and behavioral health services.

Excitingly, Koinonia Primary Care, an AMCH PPS primary care provider, has been selected as upstate New York's participant in Montefiore Care Management Organization's *Evaluation of a Continuum Based Framework for Behavioral Health Integration Among Small Primary Care Practices*. Through this project, Koinonia Primary Care and AMCH PMO staff will participate in training sessions and best practice webinars, and will receive behavioral health goal planning support that addresses the particular needs and resources of a small practice regarding behavioral health integration.

With the formation of the Behavioral Health Quality Improvement Subcommittee, and in alignment with the Phase II contract metrics, the AMCH PPS has identified a range of quality improvement activities for partners to begin to pursue related to the integration of behavioral health and primary care services. For example, as a contract metric primary care practices have been asked to develop quality improvement initiatives aimed at increasing rates depression screening and appropriate follow-up care for positive screens, and we are beginning to work with primary care practices around conducting chart audits related to this. We have also drawn from behavioral health quality metrics to identify the following topics for future partner quality improvement activities related to the integration of primary care and behavioral health services: antidepressant and antipsychotic medication adherence; diabetes screening and monitoring for people with schizophrenia and diabetes; appropriate follow-up care of patients prescribed ADHD medication; rapid initiation of and engagement in alcohol and other drug dependence treatment; and decreasing potentially preventable behavioral health ER visits. Finally, we are beginning to discuss partner adoption and use of PSYCKES for quality improvement as a quality improvement activity itself.

Mid-Point Assessment Recommendation:

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.

PPS Action Plan Narrative:

CBO Engagement

AMCH PPS has a strong commitment to engage partners across all provider types. Our aggressive speed and scale commitments, set well before project implementation, do not fully portray the commitment to project implementation success. Although project speed for four projects was set for DY2Q2, we feel that active participation of all contracted organizations shows an overwhelming engagement in our projects and a commitment to improve quality measures. Participating providers continue to strive toward Milestone completion through their ongoing and valued committee work, PCP Advisory Group, and contract deliverables. Phase I Contracting had several metrics in regards to engagement and active participation within project subcommittees and work-stream committees. These included, but were not limited to, clinical participation on the Behavioral Health project sub-committees, an EHR subcommittee comprised of both clinical experts and IT representation, and a Clinical and Quality Affairs Committee that meets monthly to bring all project-related subcommittee representatives together including Asthma, Cardiovascular Disease, Behavioral Health, Health Home At Risk Intervention, and ED Care Triage. Additionally, community participation and representation on subcommittees and committees is vital for project success; the AMCH PPS understands and encourages the need for continued engagement. We have restructured our PMO to include a community relations manager who focuses on the community need, services provided, and additional advocacy that may be necessary. The Consumer and Community Affairs Committee engages CBOs in the AMCH PPS to understand the projects and how their services can align with the overall DSRIP goals. By having contract metrics tied to the networking and sharing of services provided by CBOs and services needed by Primary Care Providers, we have created continuity for our partners across all provider types. CBO engagement is an ongoing initiative. The 2di project has contracts with the majority of our participating CBOs to provide navigation services, conduct PAMs and coaching with patients, and help to engage patients in care. The LEAD initiative is an innovative funding opportunity that allows Catholic Charities to work collaboratively with the Albany Police Department to help provide care management services for repeat, low level offenders, who would benefit greatly from healthcare/ behavioral health services. Vendor contracts for care management and care coordination services are also being developed for Phase II contracts. These engagement contracts will help provide services to patients across our continuum of care; allowing proper referrals to take place for better quality of care.

Contracting

The AMCH PPS's contracted partnering organizations serve the majority of the attributed patient population. The contracts are outlined with very specific metrics that directly impact project

participation, milestone completion, and outcome measures. Although the contracted partners do not add up to the total number of providers across all provider types that were committed to the speed and scale commitment set in January of 2015, the providers that are contracted make up the majority of the providers located within our five- county catchment area and thus, have a direct impact on all Medicaid attributed lives. The non-contracted partners that make up the difference in our speed and scale commitments predominately fall outside of the five counties and are actively participating in their local PPSs. These providers are still engaging Medicaid patients across NYS but are focused on projects in counties such as Ulster or Duchess County where our counterparts, Montefiore and Westchester PPS, are more actively engaged. It is important to note that during the very early stages of the formation of the provider network, the AMCH PPS committed to serving a geographic region of nine counties and as such were building an inclusive network with providers from Schenectady, Rensselaer, Ulster and Dutchess Counties. However, after the formalities of the attribution threshold logic were introduced, the AMCH PPS was advised to scale down the focused catchment area to its current five counties. This change continues to affect the provider network and the feasibility of reaching speed and scale commitments. Though these challenges are evident, the AMCH PPS collaborates with overlapping and nearby PPSs to align projects, ensure de-duplication of actively engaged patients, and streamline the roll-out of project initiatives to help minimize efforts of participating providers. This alignment allows us to reach all attributed lives with policy and systematic changes as a means to improve the quality of care provided. As DOH threshold logic was established late in the application phase, it would greatly benefit the AMCH PPS if the State and IA would consider a modification to the commitment numbers reflected in the previous commitments made in January of 2015. A modification will include participating providers in our five county region. A practitioner engagement template is submitted for your reference. In addition, the patient engagement commitments, as outlined in the DOH application, are set to ramp up from 0-100 over time. New guidance was provided during DY2Q2 remediation stating that patient engagement resets at 0 each year. This contradicts all guidance in commitment levels and the AMCH PPS is concerned that we will not be able to engage the total number of patients that we have projected and we therefore seek clarification on the documentation change.

Data

The AMCH PPS will continue to actively engage all provider types for successful project implementation and direct impact of our outcome measures. By utilizing multiple data resources, produced from partners, DOH, and our local RHIO, we will develop comprehensive dashboard reports that are public facing to aid in the creation of initiatives and interventions in hotspot areas with the goal being to allow participating providers to view where they are in relation to quality metrics, and to help improve care. The Medicaid Analytics Performance Portal (MAPP) remains very much an integral tool for the PMO's Data Team. Pairing the information that can be extracted from Salient and/or MAPP with the NYS DOH Medicaid claims database (in accordance with the SSP Workbooks) provides the PMO with a well-versed macro-perspective of the progress being made towards improving the primary care objectives. Furthermore, Hixny and Statewide Health Information Network for New York (SHIN-NY) are being utilized to provide linkages among numerous organizations as well as to serve as a platform for various project needs and deliverables such as connectivity, real time alerts, sharing of care plans, and registries. Lastly, the PPS is finalizing plans to implement the SpectraMedix platform, a solution which will leverage numerous data sources such as the Claims database, partner clinical and pre-adjudicated claims data, and the Hixny community health record to provide retrospective and predictive analytics specific to the PPS network. The SpectraMedix platform will help to facilitate the transition to pay for performance

and risk-based models with solutions for advanced data integration, measures calculation and regulatory reporting, and predictive modeling and at-risk patient surveillance applied to a range of performance initiatives from patient level to population level. The data will be utilized at the PMO level to look at gaps in care across the five county PPS and implement system change to benefit the population.

Care Coordination

Utilizing the Care Coordination Care Management (CCCM) Model developed in collaboration with Accenture and 26 PPS partners as a framework, the AMCH PPS is also developing a comprehensive CCCM program known as BHNNY Cares to work with downstream health home care management agencies, PCMHs and other relevant partners such as CBOs to strengthen and expand capabilities of our primary care partners. BHNNY Cares aims to identify, engage, and link eligible attributed members (health home eligible, or higher risk members not currently eligible for health homes) to appropriate CCCM resources. BHNNY Cares has defined roles for Primary Care partners that include, but are not limited to:

- Achieve NCQA 2014 PCMH or NYS Advance Primary Care (APC) – Gate 2 recognition by December, 2017.
- Embedding on-site BH services by participating in Integration of Primary Care and Behavioral Health services project (3.a.i) **or** establish partnerships with community-based BH organizations for referral and care coordination
- Implement systems to proactively identify patients in need of care coordination and care management services that require referral to external CCCM entities.
- Develop processes to review, update, and share care plans as appropriate.
- Facilitate ongoing case reviews with care management teams to discuss issues related to managing high-risk members.
- Develop processes to maximize the utilization of available IT resources for timely interventions.

BHNNY Cares applies population health concepts such as risk stratification; goals for the care team, patient, and system; appropriate and intentional care teams who are activated based on the identified needs of the patient(s).

Primary Care

Primary care is essential to improving patient health and providing equitable access to health care. The AMCH PPS recognizes that a seamless linkage between episodic care, such as hospital inpatient and emergent care services, and primary care is critical to ensure a full continuum of care for our patients. Therefore, utilizing the following strategies, the AMCH PPS focus is to assure that primary care physicians (PCPs) are key players who orchestrate other members of the integrated delivery system (IDS). The AMCH PPS has implemented several engagement strategies across all provider types. This detailed strategy is outlined in the AMCH PPS Primary Care plan but a summary of activities is below.

The AMCH PPS has developed a Clinical Integration/Care Coordination Model (CI/CCM) that fully describes the future state in which PCPs play a central role. Under this model, community-based primary care is a critical component of the cyclical continuum of care coordination from acute to community settings. To date, the AMCH PPS has adopted various parts of this model, including training on CI/CCM

offered to clinical and administrative staff, improvement of HIXNY connectivity and placement of care coordinators in various clinical settings such as EDs and PCP offices.

The PCMH initiative will be a key component of engaging primary care providers across the AMCH PPS. The AMCH PPS has engaged HANYS, through an RFP process, to support Tier I and Tier II PCMH certification processes. In total, there will be nine practice sites that will need 1:1 training. In Tier II, the PPS is providing all 11 organizations an opportunity to participate in the group training/learning collaboratives. This equals up to 78 participating primary care sites in total. During the project planning phase, HANYS will assess practice readiness Following this assessment, During the Tier I engagement, HANYS will provide scheduled web based interactive advisory sessions, a client learning platform with required learning modules to be completed by the practice, policy and procedure templates, as well as personalized support from a PCMH advisor for task management throughout the transformation at the practice level. Additionally, HANYS will be providing a "train the trainer" approach whereby the PCMH advisor will work with a practice level facilitator to complete training with the practice during staff meetings. This will also assist with sustainability efforts after recognition is achieved. For Tier II practices, HANYS will offer in person learning collaboratives to 78 practice sites whereby key clinical and administrative leaders will attend. HANYS will provide one in person, three hour learning collaboratives on a quarterly basis until the completion of the engagement. All sessions are focused on the NCQA standards well as other key topics such as auditing, submission and documentation requirements. A core component to successful maintenance of NCQA PCMH Level recognition is a robust sustainability plan, and HANYS has woven into every aspect of the practice engagement and communication. HANYS will be working with the clinical manager to assure sustainability post engagement. The clinical manager for the PPS will also be available during the engagement to offer basic technical support and respond to inquiries that practices may have or to serve as a liaison between practices and the vendor or NCQA.

Additionally, the AMCH PPS is in the planning phase of implementing a recruitment and retention fund modeled after the strategy implemented by AHI PPS. This retention and recruitment fund is intended to support participating providers in addressing access to primary care in an effort to transform health care within the AMCH PPS five county catchment area. It is the intent of the lead agency as part of the PPS' workforce strategy, to recruit and retain primary care practitioners to expand access to primary care services.

Health Homes/Behavioral Health

Additionally, the AMCH PPS has placed a strong emphasis on linkages to Health Homes and Behavioral Health Providers within several clinical projects, to encourage improved linkages to their local PCPs/PCMHs. By working directly with primary care practices and other secondary and tertiary service providers, the AMCH PPS acts as a liaison and foster relationships between providers who often did not collaborate prior to DSRIP. This reflected in the AMCH PPS governance structure where provider representation is evident in the PPS Leadership Committee, the Clinical and Quality Affairs Committee, and all associated project subcommittees. This committees and subcommittees play a valuable role in project implementation. All policies, procedures, and best practices are reviewed at the subcommittee level and reported all the way up to the board for approval. This allows for participating providers to play a lead role in implementation. In addition to the governance structure that includes PCPs, the Primary Care Advisory Group was established in August 2016 to create another avenue for PCPs to become involved in our PPS activities. This advisory group consists of PCPs from institutional-based and community-based practices that provide insight and expertise on DSRIP initiatives related to

strengthening the primary care system. This group will continue to meet on a regular basis to offer guidance and input on the AMCH PPS's project implementation and transformational efforts.

Funds Flow

AMCH PPS PMO, in collaboration with COPE Health Solutions, has created a funds flow methodology that supports the PPS network and will enable the PPS to achieve the State-required milestones and metrics. Over the course of the first phase of this contracting process, which covered the period from 4/1/2015 through 12/31/2016, refined deliverables were created that range from project or work stream specific, to reporting or engagement. The funds were allocated based on provider type, project participation, and attributed lives. $9.7 million was allocated to partner organizations during the first phase of contracting as described above. As of February 2017, over $5.6 million dollars in total has been distributed to partner organizations from the first phase of contracting. Approximately $4.7 million of the total dollars funded was to organizations that offer primary care. The PMO is actively working with partners to complete several deliverables that will yield an additional $3-4 million in distributions.

The first phase of contracting was developed to engage partners and begin initial steps towards building an integrated delivery system. Partners were paid for various activities ranging from attending monthly PAC meetings, completing various work stream and project-specific training initiatives, providing data requests, and developing and adopting policies/protocols and best practice guidelines. Example contract metrics include submission of project-specific patient engagement and registries templates, develop an approved Care Manager/Coordinator job description, adopt evidence based guidelines for asthma, and complete required training for CCHL, IT, performance reporting, and clinical integration. Additionally, partners were required to develop and adopt patient navigator, screening tool, crisis services and referrals, follow-up blood pressure checks, and medication regimen simplification policies and procedures. The work completed in the Phase I contracts provides the PPS and its partners with the foundation necessary to implement the work streams and projects in the five-county region.

Development of the second phase of contracts was a coordinated effort between the PMO, COPE Health Solutions, and several partner organizations. Draft metrics were brought to various committees for their feedback. This process helped ensure the metrics were developed by the clinicians in the network and helped AMCH PPS obtain buy-in from the partner organizations.

AMCH PPS has allocated $13 million to all partner organizations for the second phase of contracting, which covers the period from 1/1/2017 through 3/31/2018. This phase focuses not only on performance activities, such as policy and procedure development, meeting participation, and patient engagement/registries, but also includes several metrics specific to the required outcome measures. To ensure alignment with DSRIP objectives, partners will receive funding for outcome measures when the PPS achieves its performance goals. The goal of Phase II contracts is to start to shift the funding from activities to outcome measures. This results in partners sharing the risk associated with these measures, which is in line with the ultimate goal of transitioning to a value-based payment structure.

In this second phase, 75% of the funding allocated to each partner will be achieved through performance activities, while the remaining 25% will be earned through outcome measures. Partners will be required to complete "prerequisite" activities to be eligible for any payment of funds. Examples of prerequisite metrics include attending PAC meetings, completing a financial sustainability assessment, attend CCHL champion meetings, and attend VBP education sessions. The PPS also incorporated the concept of "bundle" metrics into the Phase II contracts. Bundle metrics require a

partner to complete a series of related activities in order to obtain the full amount of funding associated with them. For example, partners participating in the ED Care Triage project must complete both quarterly data requests that show follow-up appointments with a patient's PCP and they must compile a list of high utilizers in order to receive the full amount of funding allocated to that bundle.

In future contracting phases, AMCH PPS anticipates that the funds flow model will continue to evolve towards outcomes-based payments, in alignment with the transition of the DSRIP program towards pay-for-performance in DY 4-5.

The attached funds flow template reflects, funds projected to be distributed to partners through DY2 as well as the projected portion of earned dollars to be distributed by provider type in years DY3-DY5. It should be noted that distributions reflected in the "Hospital – Inpatient/ED" category includes the physician practices associated with the partner hospitals in the AMCH PPS. These hospital-affiliated practices account for 28% of AMCH PPS network primary care physicians, 50% of the network non-primary care providers, and 10% of the mental health providers.

Project Risk Mitigation

While the AMCH PPS has faced challenges, including an aggressive speed and scale timeline matched with the absence of capital funding to promote advanced technology and innovation, the PMO is confident that continued innovative collaboration within the participating provider network will help to alleviate said challenges. The AMCH PPS has a detailed strategy in place for all 11 projects, including the three projects described below that received a risk score of 3 or higher. The PPS is committed to full implementation all projects as approved by DOH and the IA to meet all milestones and therefore improve outcome measures.

For project 2.b.iii- ED Care Triage, the AMCH PPS is identifying additional meaningful tasks to support the overall project objective of developing an evidence-based care coordination and transitional care program that will assist patients to link with a primary care physician/practitioner, support patient confidence in understanding and self-management of personal health condition(s), improve provider to provider communication, and provide supportive assistance to transitioning members to the least restrictive environment. The AMCH PPS **met 3 out of 4** project requirements by the committed implementation date. The AMCH PPS's strategy outlines all action items to support the achievement of overall project objective of assisting patients with access to primary care services while supporting their self-management abilities. A full detailed report can be found under Recommendation #2 but a summary is below.

As outlined above, The AMCH PPS has made progress in achievement toward NCQA Level 3 PCMH and/or APC recognition. Health Care Association of New York State (HANYS) has been chosen as the vendor to support the PPS in its PCMH transformation efforts. Additionally, in December 2016, HANYS was awarded a technical assistance contract with New York State to partner with primary care practices across the state and guide them through the transformation to Advanced Primary Care (APC). This dual designation will further strengthen transformation efforts on behalf of the PPS.

To understand and address region specific issues impacting collaboration between EDs and primary care practices, beginning in November 2016, the participating hospitals began hosting regional meetings with staff from the Emergency Department, hospital, primary care practices, and behavioral health

organizations. These meetings were intended to assist us in determining regional best practices, priorities and challenges while identifying steps to foster communication between the ED and PCP to reduce the barriers patients experience when transitioning between these two locations. These meetings will continue to be held on a rotating basis.

Finally, as part of the Clinical Integration strategy the AMCH PPS will continue efforts to strengthen the connectivity between EDs and primary care practices by enhancing the clinically interoperable system as outlined in recommendation #1.

For project 3.d.iii- Asthma Project, the AMCH PPS is identifying additional meaningful tasks to support the overall project objective of implementing evidence based medicine guidelines for asthma management to ensure consistent care. The AMCH PPS **met 3 out of the 5** project requirements by the committed implementation date. The PPS's strategy outlines all action items to support the achievement of overall project objective to support the implementation of evidence-based medicine guidelines, utilization of asthma action plans (AAP), and access to specialists.

The corrective action plan put in place to address milestones not completed by 9/30/2016 includes several components: refining/identifying additional tasks and timelines, including the implementation of a Project ECHO/ telemedicine platform, focusing on and continuing to improve patient and provider engagement and commitment. For example, while milestone 3 (provider education) was completed, educational activities will be ongoing throughout the course of DSRIP. Data from sources including the 2016 HCDI Community Needs Assessment, and February 2017 Asthma Health Equity Report from HCDI continues to inform how we will prioritize and focus tasks to address the asthma burden in our region – for example Albany sees a significant disparity in asthma hospital and ED use for its lowest income neighborhoods. Further detail can be found in Recommendation #4.

AMCH PPS continues to engage Practitioners (PCPs & Non-PCPs), Hospitals (Inpatient & ED units), Clinics, Health Homes, Pharmacies, Local Health Departments, and CBOs in the oversight of 3.d.iii as appropriate. CBO engagement provides valuable resources and insights into addressing social determinants of health and environmental assessment and trigger education at the home level. Productive discussions have also ensued with The Center for Disability Services, and in all likelihood they will come on board for 3.d.iii. Specialist engagement has proven challenging, due to patient care demands; however, our lead hospital has recruited a Pulmonologist with an interest in asthma, to start in March 2017. Columbia Memorial Health (CMH) has identified a Nurse Practitioner who has championed previous asthma efforts and will work as a nurse liaison across CMH sites to support engagement and implementation of the asthma project.

For Project 3.b.i- Cardiovascular Disease Project, the AMCH PPS is identifying additional meaningful tasks to achieve the overall project objective of supporting the implementation of evidence-based best practices for disease management in medical practice for adults with cardiovascular conditions. The AMCH PPS **met 9 out of 20** project requirements by the committed implementation date. The PPS's strategy outlines all action items to support the achievement of overall project objective as outlined in the Million Hearts Action Guides for controlling hypertension and for identifying and treating patients who use tobacco.

The corrective action plan put in place to address milestones not completed by 9/30/2016 includes several components: refining/identifying additional tasks and timelines, focusing on and continuing to

improve patient and provider engagement numbers, and continuing to build on success that was attained through DY2Q2. For example, while milestone 8 ("walk-in BP screening") was completed, there will be ongoing incentives for participating practices to continue to offer the service in order to improve access for primary care services for patients with hypertension. A full detailed report can be found under Recommendation #3 but a summary is below.

The AMCH PPS will track progress through a robust set of contract metrics. Clinical leads from across the PPS were invited to participate in the development of Phase II contracts. The metrics will directly impact deliverables and align with the 3.b.i action plan. Roles and responsibilities of partners are defined in the contract metrics. In several cases metrics may be defined as hurdle metrics or bundle metrics, to ensure successful completion of tasks that are necessary in order to effectively implement the project. For example, the PPS is linking project incentives to implementing staff training and competency assessment of the measurement of blood pressure, which is a metric that is bundled with other metrics that will direct appropriate identification and management of patients with hypertension. The PPS will also utilize a data analytics tool that will leverage data sources such as MAPP to provide analytics specific to our PPS and projects.

Contracted organizations will continue to be represented on clinical committees and subcommittees, as noted in the Primary Care Plan. AMCH PPS will continue to engage Practitioners (PCPs & Non-PCPs), Hospitals (Inpatient & ED units), Clinics, Health Homes, Pharmacies, Local Health Departments, and CBOs in the oversight of 3.b.i as appropriate. CBO engagement provides valuable resources and insights into addressing social determinants of health. Productive discussions have also ensued with Albany County Health Department to support the home blood pressure monitoring initiative.

Hypertension and other cardiovascular diseases are also eligible conditions for the Health Home At Risk Project, which is currently piloting a program with CMH and four care management agencies (CMA.) As noted in the Primary Care Plan, BHNNY (Better Health for Northeast NY) Cares care coordination/ care management program will work with downstream health home CMAs and other regional partners to support transitions of care for patients discharged from ED or hospital, and direct to appropriate resources such as community care coordination, and health home services, further strengthening services and linkages for patients with cardiovascular conditions.

The AMCH PPS activities align with the overall DSRIP project objectives by assisting practitioners to improve the overall health status of patients with CVD and implementing the Million Hearts strategy in order to support these efforts. By aligning these efforts in the CVD project with the overall DSRIP goals, we will reduce avoidable hospitalizations and ED admissions for patients with CVD. The AMCH PPS is committed to the completion of this project and confident that we will meet the project timeline of 9/30/2017.

Summary

The AMCH PPS recognizes that an aggressive speed and scale commitment, early on, has led to a structure that, on the outside seems to be a lot of strategy but not real implementation. This is not the case. The strategy and implementation of an integrated delivery system is well under way and the

engagement of our providers continues to grow. Partners of all provider types are actively participating in group sessions, committee meetings, and overall DSRIP initiatives with the shared goal of improving the quality of healthcare across the entire continuum. The full implementation of all projects to include system change, policy change, and culture change, will ultimately create an Integrated Delivery System to benefit the population in its entirety. Though challenges exist and the change ahead is not easy, the AMCH PPS remains very much committed to fully implementing projects with the goal of significantly impacting outcome measures while reducing avoidable ED visits and unnecessary readmission rates. The full implementation plan of the AMC PPS strategy, as outlined above, will be completed by September, 2017, as required by DOH. The detailed roll out of this plan can be found in all associated implementation plans submitted with requirements 1-8.

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		***Insert Project (i.e. 2.a.i.)***	***Insert Project (i.e. 2.a.i.)***	***Insert Project (i.e. 2.a.i.)***	***Insert Project (i.e. 2.a.i.)***	***Insert Project (i.e. 2.a.i.)***	***Insert Project (i.e. 2.a.i.)***	***Insert Project (i.e. 2.a.i.)***	***Insert Project (i.e. 2.a.i.)***	***Insert Project (i.e. 2.a.i.)***	***Insert Project (i.e. 2.a.i.)***	***Insert Project (i.e. 2.a.i.)***
Practitioner - Primary Care		490	319	205	315	406	420	265	319	424		
Practitioner - Non-Primary Care		1769	1220	516	1204	1231	1247	1099	1187	1119		
Clinic		16	8	2	8	13	8	6	7	6		
Mental Health		167	87	23	81	89	93	97	66	61		
Substance Abuse		11	2	2		2	6	6	1	1		
Case Management		25	15	4	15	14	12	17	9	4		
Hospital - Inpatient/ED		4	3	1	3	3	3	3	3	3		
Health Home		1	1									
Community Based Organization (Tier 1)		26	4	18	5	7	3	4		3		
Nursing Home		10	2	5	2	2	2	2	2	1		
Pharmacy		4	3	1	4	4	4	3	3	3		
All Other		1539	1062	564	1076	1171	1183	904	1074	1160		
Uncategorized		246	211	104	204	208	213	188	155	146		
Other (Define)												

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

		Funds Flow (all funds)			
Partner Category		***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		194,849	1,797,243	14.02%	41.69%
Practitioner - Non-Primary Care			-	0.00%	0.00%
Hospital - Inpatient/ED		2,408,913	4,670,545	24.68%	68.70%
Hospital - Ambulatory			-	0.00%	0.00%
Clinic		100,296	224,312	0.43%	1.61%
Mental Health		264,025	363,916	2.28%	14.09%
Substance Abuse		37,473	51,008	0.78%	4.99%
Case Management/Health Home		131,617	172,799	1.78%	10.86%
Health Home			-	0.00%	0.00%
Community Based Organization (Tier 1)		43,798	63,538	0.92%	2.94%
Nursing Home		30,157	50,662	0.31%	1.17%
Pharmacy			-	0.00%	0.00%
Hospice			-	0.00%	0.00%
Other - Home Health, OPWDD, other		818,013	1,130,657	0.21%	0.73%
Uncategorized		186,265	261,847	0.00%	0.00%
Additional Providers		36,948	36,948	0.00%	0.00%
PPS PMO		6,932,904	8,478,606	37.88%	62.31%
Total		**11,185,257**	**17,302,080**	**83.28%**	**209.10%**

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

Mid-Point Assessment Recommendation #1:	
PPS Defined Milestones/Tasks	***Target Completion Date***
Milestone 1: All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary to support its strategy.	9/31/2017
Task 1: Distribute Phase II contracts to participating organizations, covering the wide-array of provider types including medical, behavioral, post-acute, long-term care, and CBOs with the focus on milestone completion, improving outcome measures, and system change	9/31/2017
Task 2: Engage organizations in committee meetings and subcommittee meetings to develop best practices, standards of care, and full implementation of project initiatives	9/31/2017
Task 3: Maintain close working relationship with Hixny to collaboratively work with contracted partners to establish bi-directional connectivity	9/31/2017
Task 4: Monitor progress of connectivity and align with the SHIN-NY RHIO connectivity requirements pursuant to SHIN-NY Regulation- 10 NYCRR Part 300	9/31/2017
Task 5: Implement Analytics platform and Centralized Care Coordination services	9/31/2017
Task 6: Implement AMCH PPS IDS model across all required provider types with a focus on partner system integration via Hixny.	9/31/2017
Milestone 3. Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.	9/31/2017
Metric 1: Clinically Interoperable System is in place for all participating providers.	9/31/2017
M1:1. Establish, under the auspices of the AMCH PPS Technology and Data Management Committee (TDMC), an ad- hoc project sub-committee to oversee the development and implementation of the action plan to assure PPS-wide EHR connectivity to the SHIN-NY and HIEs. Ensure key representation from identified providers and partners on the project sub-committee.	Complete

M1:2. Perform a current state assessment on the participating provider organizations' EHR systems' features and capabilities for connectivity to SHIN-NY and HIXNY.	Complete
M1:3. Utilizing the IT-TOM pilot experience, design the PPS- wide future state connectivity model.	Complete
M1:4. Complete a gap-analysis utilizing the current state assessment and defined future state, creating an implementation plan and a phased roll-out.	Complete
M1:5. Update the current state assessment and defined future state for all contracted partners, creating an updated implementation plan and a phased roll-out for contracted partners requiring connectivity.	9/31/2017
M1:6. Work with participating providers, not currently connected to a RHIO, to pursue Data Exchange Incentive Program (DEIP) opportunities to fund RHIO connectivity costs	9/31/2017
M1:7. All RHIO eligible contracted partners have signed Hixny QE and DSRIP Hixny One-To-One Exchange Agreements and connectivity has been established with Hixny (RHIO) that meets minimum requirements as defined by PPS.	9/31/2017
M1:8. Monitor progress on the ability to share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look-up, and support timely care management decisions.	9/31/2017
Metric 2: PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS.	9/31/2017
M2:1. AMCH PMO will identify the current state of care coordination, services and workflow. AMCH PMO will create the future state of what collaboration linkages need to be created to ensure successful implementation over the DSRIP five year program.	Complete
M2:2. AMCH PMO will complete a gap-analysis utilizing the current state assessment and defined future state and, working in collaboration with partners, develop an action plan for the implementation of the IDS model.	Complete
M2:3. AMCH PMO will implement the approved action plan utilizing the PDSA approach in our southern hub (Columbia and Greene County).	Complete

M2:4. Utilizing the PPS's Analytics and Care Management platforms the AMCH PMO will monitor ongoing performance, analyze clinical and operational outcomes and identify timelines/practice sites for spread of successful tests of change.	9/30/2017
M2:5. AMCH PMO, in collaboration with the CQAC, will conduct a thorough review of existing care management and coordination protocols to select nationally recognized best practices to meet various project requirements and milestones required for transformation and patient engagement.	Complete
M2:6. AMCH PMO, in collaboration with the TDMC, will build upon existing platforms and develop short-term solutions for integration including protocols in place for care coordination and processes for tracking care outside of hospitals to ensure care follow up.	6/30/2017
M2:7. AMCH PMO in collaboration with the CCAC will conduct consumer focus groups and surveys regularly to understand the level of patient engagement and PCP utilization.	9/31/2017
Metric 3: PPS has process for tracking care outside the hospitals to ensure that all critical follow-up services and appointment reminders are followed.	9/31/2017
M3:1. CQAC will create a behavioral health subcommittee to ensure that mental health and substance abuse providers are participating in the IDS.	Complete
M3:2. All contracted PCPs, and Care Coordinators subscribe to Hixny-Generated alerts and develop protocols to follow-up with patients discharged from the hospital/ED within 48-72 hours of discharge	9/31/2017
M3:3. All Hospital partners adopt and implement the LACE Scoring Tool and develop a process for sharing the score the patient's community care team (PCPs, Mental Health Providers, Care Managers, Nursing Homes and Specialty Care Providers) post discharge.	9/31/2017
M3.4 Post acute providers (PCPs, Mental Health Providers, Care Managers, Nursing Homes and Specialty Care Providers) utilize the LACE score to develop the Care Plan and Education required for at risk patients.	9/31/2017

M3:5 PPS Providers provide patient education on appropriate ED use and alternate resources.	9/31/2017
M3:6. Hospitals develop protocols to track and ensure discharge summaries are provided to providers responsible for post-acute care within 48-72 hours post discharge.	9/31/2017
M3:7 All Mental Health and Primary Care Providers participating in Project 3.a.i develop and demonstrate that protocols have been adopted to provide follow-up care and outreach to patients hospitalized for Mental Illness and schedule follow-up appointments.	9/31/2017
M3:8 Mental Health and Primary Care Providers partner with Care Coordinators to provide outreach to patients that miss follow-up appointments.	9/31/2017
M3:9 PPS Hospitals and Emergency Departments demonstrate compliance with the state's Health Home referral requirement for Health Home-eligible patients.	9/31/2017
M3:10 AMCH PMO in collaboration with the WCC will provide training regarding IDS protocols and processes.	9/31/2017
Milestone 4: Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including directed exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.	9/31/2017
Metric 1: EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	9/31/2017
M1:1. Establish, under the auspices of the AMCH PPS Technology and Data Management Committee (TDMC), an ad-hoc project sub-committee to oversee the development and implementation of the action plan to assure PPS-wide EHR connectivity to the SHIN-NY and HIEs. Ensure key representation from identified providers and partners on the project sub-committee.	Complete
M1:2. Perform a current state assessment on the participating provider organizations' EHR systems' features and capabilities for connectivity to SHIN-NY and HIXNY.	Complete

M1:3. Utilizing the IT-TOM pilot experience, design the PPS- wide future state connectivity model.	Complete
M1:4 Complete a gap-analysis utilizing the current state assessment and defined future state, creating an implementation plan and a phased roll-out.	9/31/2017
M1:5. Update the current state assessment and defined future state for all contracted partners, creating an updated implementation plan and a phased roll-out for contracted partners requiring connectivity.	9/31/2017
M1:6. All RHIO eligible contracted partners have signed Hixny QE and DSRIP Hixny One-To-One Exchange Agreements and connectivity has been established with Hixny (RHIO) that meets minimum requirements as defined by PPS.	9/31/2017
M1:7. Work with participating providers, not currently connected to a RHIO, to pursue Data Exchange Incentive Program (DEIP) opportunities to fund RHIO connectivity costs.	9/31/2017
M1:8. Monitor progress on the ability to share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look-up, and support timely care management decisions.	9/31/2017
Metric 2: PPS uses alerts and secure messaging functionality.	9/31/2017
M2:1. Perform a current state assessment on the interconnected systems' ability to send, receive and use alerts and secure messages to facilitate timely care coordination and management.	Complete
M2:2. Define the future state and select appropriate vendor for implementation of alerts and secure messaging functionality by clinicians and staff across the Integrated Delivery System for safe and effective care transitions between EDs, hospitals, specialists and PCMH sites.	Complete
M2:3. Conduct a gap analysis between current state and future state of using alerts and secure messaging functionalities for timely care coordination.	Complete

M2.4 Update current state assessment of contracted partners in the interconnected systems' ability to send, receive and use alerts and secure messages to facilitate timely care coordination and management.	9/31/2017
M2.5. Utilize Hixny and SHIN-NY to support the use of ADT alerts across the PPS.	9/31/2017
M2.6.Implement protocols developed to be followed upon receipt of Hixny-generated alerts/and hospital discharge summaries.	9/31/2017
M2:7. Monitor progress on the ability to share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look-up, and support timely care management decisions.	9/31/2017
Milestone 5: Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	9/31/2017
Metric 1. EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria	9/31/2017
Task 1. Perform a current state assessment of participating safety-net providers' EHR systems' readiness to meet Meaningful Use (MU) Stage 2 CMS requirements.	9/31/2017
Task 2. Ensure clinician and staff training on new processes is conducted.	9/31/2017
Task 3. Require participating safety-net providers to attest that their EHR system meets MU Stage 2 CMS requirements.	9/31/2017
Metric 2. PPS has achieved NCQA Level 3 PCMH standards and/or APCM.	9/31/2017

Task 1. Establish a project sub-committee with representation from all participating primary care practitioners to facilitate and assure achievement of 2014 NCQA Level 3 PCMH recognition or APCM by DY 3.	9/31/2017
Task 2. Implement training sessions for senior leaders, clinicians and staff to learn about the benefits of achieving 2014 NCQA Level 3 PCMH recognition or APCM.	9/31/2017
Task 3. Working in collaboration with HANYS Practice solutions, perform a current state assessment of participating practices' capabilities to provide patient-centered care consistent with the NCQA 2014 Level 3 PCMH/APC standards	9/31/2017
Task 4. Perform a practice-specific gap analysis to determine the needed financial, technical and operational support needed to assure successful recognition by DY3.	9/31/2017
Task 5. Based on the gap analysis, establish priorities and develop a practice specific action plan to achieve the recognition and transform the care delivery model.	9/31/2017
Task 6. Create a learning collaborative for participating safety-net providers to assist in the development of necessary workflows and other changes to become NCQA Level 3 certified or APCM.	9/31/2017
Task 7. Assign specific roles and responsibilities for the participating practice leadership and timelines to implement the action plan effectively and achieve the recognition by DY 3.	9/31/2017
Task 8. Working in collaboration with HANYS Practice Solutions, monitor progress on a monthly basis to evaluate progress and assess needed additional resources to support practice transformation.	9/31/2017
Milestone 9: Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	9/31/2017
Task 1: AMCH PMO will engage Medicaid MCOs in broader areas of concern to the PPS, including financial sustainability, risk sharing, and compliance with competitive behaviors. This will be done by scheduling regularly occurring meetings with MCOs and the PMO.	9/31/2017

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

Mid-Point Assessment Recommendation #1: The IA recommends that the PPS develop a corrective action plan to successfully complete the project requirement that was not completed by the PPS Speed & Scale commitment date for this project. The PPS must provide a revised timeline fir the completion of the one project requirement that was not completed by DY2, Q2 as part of this action plan.

PPS Defined Milestones/Tasks	*Target Completi*
1. INSERT MILESTONE 2: Participating ED s will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling.	**Completion Date**
a) Achieve NCQA 2014 Level 3 Medical Home Standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3.	
b) Develop process and procedures to establish connectivity between the emergency department and community primary care providers.	
c) Ensure real time notification to a Health Home care manager as applicable.	
Metric 1 : All practices must meet NCQA 2014 Level 3 PCMH and/or APCM standards.	3/31/2018
Task 1. Establish a project sub-committee with representation from all participating primary care practitioners to facilitate and assure achievement of 2014 NCQAC Level 3 PCMH recognition or APCM by DY 3.	Completed
Task 2. Implement training sessions for senior leaders, clinicians and staff to learn about the benefits of achieving 2014 NCQAC Level 3 PCMH recognition or APCM.	Completed 7/13/2016 & 7/14/2016
Task 3. Working in collaboration with HANYS Practice solutions, perform a current state assessment of participating practices' capabilities to provide patient-centered care consistent with the NCQA 2014 Level 3 PCMH/APC standards	6/30/2017
Task 4. Perform a practice-specific gap analysis to determine the needed technical and operational support needed to assure successful recognition by DY3.	6/30/2017
Task 5. Based on the gap analysis, establish priorities and develop a practice specific action plan to achieve the recognition and transform the care delivery model.	6/30/2017
Task 6. Create a learning collaborative for participating safety-net providers to assist in the development of necessary workflows and other changes to become NCQAC Level 3 certified or APCM.	6/30/2017
Task 7. Assign specific roles and responsibilities for the participating practice leadership and timelines to implement the action plan effectively and achieve the recognition by DY 3.	6/30/2017
Task 8. Working in collaboration with HANYS Practice Solutions, monitor progress on a monthly basis to evaluate progress and assess needed additional resources to support practice transformation.	9/30/2017

Task 9. Facilitate partnerships between participating EDs and community primary care providers including PCMHs to develop open-access models to assure timely access.	9/30/2017
Task 10. Demonstrate ability to provide patient-centered appointment access at primary care sites consistent with PCMH/APC standards.	9/30/2017
Task 11. Designate staff at participating primary care sites as contacts for ED care coordinators/patient navigators for access and care coordination needs.	6/30/2017
Task 12. Implement protocols to assure timely access and effective communication for care transitions between ED and community primary care practices.	9/30/2017
Task 13 - Develop protocols to provide discharge summaries to providers that will be responsible for follow up care within 48-72 hours after discharge. Track providers that have been notified of required follow up care after patient discharge.	9/30/2017
Task 14 - Implement PPS wide care coordination care management program and train partners on how to refer and which patients to refer for services.	9/30/2017
Task 15 - Identify and train individual(s) that will provide patient navigator services in ED setting.	6/30/2017
Task 16 - Develop Emergency Department process flow to include patient triage, referral, patient review and assessment.	Complete 9/07/2016
Task 17 - Implement Emergency Department process flow to include patient triage, referral, patient review and assessment.	9/30/2017
Task 18. ED care coordinator/patient navigator will assure timely notification to the patient's Health Home care manager as applicable.	6/30/2017
Task 19. Provide training to ED and practice staff on the new protocols to assure adherence.	6/30/2017
Metric 2: E H R meets Meaningful Use Stage 2 CMS requirements.	9/30/2017
Task 1. Perform a current state assessment of participating safety-net providers' E H R systems' readiness to meet Meaningful Use (MU) Stage 2 CMS requirements.	Complete
Task 2. Ensure clinician and staff training on new processes is conducted.	Complete
Task 3. Require participating safety-net providers to attest that their E H R system meets MU Stage 2 CMS requirements.	Complete
Metric 3: Encounter Notification Service (ENS) is installed in all PCP offices and ED s.	
Task 1. Perform a current state assessment on the interconnected systems' ability to send, receive and use alerts and secure messages to facilitate timely care coordination and management.	Complete

Task 2. Update current state assessment of contracted partners in the interconnected systems' ability to send, receive, and use alerts and secure messages to facilitate timely care coordination and management.	6/30/2017
Task 3. Define the future state and select appropriate vendor for implementation of alerts and secure messaging functionality by clinicians and staff across the Integrated Delivery System for sage and effective care transitions between Ends, Hospitals, specialists, and PCMH site.	Complete
task 4. Conduct a gap analysis between current state and future state of all contracted partners of using alerts and secure messaging functionality for time care coordination and community based coordination.	Complete
Task 5. Utilize Hixny and SHIN-NY to support the use of ADT alerts across the PPS.	9/30/2017
Task 6.Implement protocols developed to be followed upon receipt of Hixny-generated alerts/and hospital discharge summaries.	6/30/2017
Task 7. Monitor progress on the ability to share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look-up, and support timely care management decisions.	9/30/2017

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

Mid-Point Assessment Recommendation #3: The IA recommends that the PPS develop a corrective action plan to successfully complete the project requirements that the IA determined were not completed by the PPS Speed & Scale commitment date for this project. The PPS must provide a revised timeline for the completion of the 13 project requirements that were not completed by DY2, Q2 as part of this action plan.

PPS Defined Milestones/Tasks	*Target Completion Date*
1. (Formerly Milestone 2) Ensure that all PPS safety net providers are actively connected EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up by the end of Demonstration Year (DY) 3.	9/30/2017
Metric 1. EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	9/30/2017
Task 1. Establish, under the auspices of the AMCH PPS Technology and Data Management Committee (TDMC), an ad-hoc project sub-committee to oversee the development and implementation of the action plan to assure PPS wide EHR connectivity to the SHIN-NY and HIEs. Ensure key representation from identified providers and partners on the project sub-committee.	Complete
Task 2. Perform a current state assessment on the participating provider organizations' EHR systems' features and capabilities for connectivity to SHIN- NY and HIXNY.	Complete
Task 3. Work with participating providers, not currently connected to a RHIO, to pursue Data Exchange Incentive Program (DEIP) opportunities to fund RHIO connectivity costs.	6/30/2017
Task 4. Update the current state assessment and defined future state for all contracted partners, creating an updated implementation plan and a phased roll-out for contracted partners requiring connectivity.	6/30/2017
Task 5. All RHIO eligible contracted partners have signed Hixny QE and DSRIP Hixny One-To-One Exchange Agreements and connectivity has been established with Hixny (RHIO) that meets minimum requirements as defined by PPS.	6/30/2017

Task 6. Monitor progress for the contracted partner's ability to share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look-up, and support timely care management decisions.	9/30/2017
Metric 2. PPS uses alerts and secure messaging functionality.	9/30/2017
Task 1. Perform a current state assessment of contracted partners in the interconnected systems' ability to send, receive and use alerts and secure messages to facilitate timely care coordination and management.	Complete
Task 2. Update current state assessment of contracted partners in the interconnected systems' ability to send, receive and use alerts and secure messages to facilitate timely care coordination and management.	6/30/2017
Task 3. Define the future state and select appropriate vendor for implementation of alerts and secure messaging functionality by clinicians and staff across the Integrated Delivery System for safe and effective care transitions between EDs, Hospitals, specialists and PCMH site.	Complete
Task 4: Conduct a gap analysis between current state and future state of all contracted partners of using alerts and secure messaging functionalities for timely care coordination and community based coordination.	Complete
Task 5. Utilize Hixny and SHIN-NY to support the use of ADT alerts across the PPS.	9/30/2017
Task 6. Develop and Implement protocols at participating primary care practices to act on Hixny-generated alerts/and hospital discharge summaries.	6/30/2017
Task 7. Monitor progress on the partner's ability to share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look-up, and support timely care management decisions.	9/30/2017
2. (Formerly Milestone 3) Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year (DY) 3.	9/30/2017
Metric 1. EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria	9/30/2017
Task 1. Perform a current state assessment of participating safety-net providers' EHR systems' readiness to meet Meaningful Use (MU) Stage 2 CMS requirements.	Complete
Task 2. Ensure clinician and staff training on new processes is conducted.	Complete
Task 3. Require participating safety-net providers to attest that their EHR system meets MU Stage 2 CMS requirements.	Complete

Metric 2. PPS has achieved NCQA Level 3 PCMH standards and/or APCM.	9/30/2017
Task 1. Establish a project sub-committee with representation from all participating primary care practitioners to facilitate and assure achievement of 2014 NCQA Level 3 PCMH recognition or APCM by DY 3.	Complete
Task 2. Implement training sessions for senior leaders, clinicians and staff to learn about the benefits of achieving 2014 NCQA Level 3 PCMH recognition or APCM.	Complete
Task 3. Working in collaboration with HANYS Practice solutions, perform a current state assessment of participating practices' capabilities to provide patient-centered care consistent with the NCQA 2014 Level 3 PCMH/APC standards	6/30/2017
Task 4. Perform a practice-specific gap analysis to determine the needed financial, technical and operational support needed to assure successful recognition by DY3.	6/30/2017
Task 5. Based on the gap analysis, establish priorities and develop a practice specific action plan to achieve the recognition and transform the care delivery model.	6/30/2017
Task 6. Create a learning collaborative for participating safety-net providers to assist in the development of necessary workflows and other changes to become NCQA Level 3 certified or APCM.	9/30/2017
Task 7. Assign specific roles and responsibilities for the participating practice leadership and timelines to implement the action plan effectively and achieve the recognition by DY 3.	6/30/2017
Task 8. Working in collaboration with HANYS Practice Solutions, monitor progress on a monthly basis to evaluate progress and assess needed additional resources to support practice transformation.	9/30/2017
3. (Formerly Milestone 5) Use the EHR to prompt providers to complete the 5A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	9/30/2017
Metric 1. PPS has implemented an automated or work driver scheduling system to facilitate tobacco control protocols.	9/30/2017
Task 1. The EHR Subcommittee will provide support for the development and/or update of Clinical Decision Support Systems (CDSS) in EHR systems across the PPS to prompt providers to complete the 5 A's of tobacco control.	Complete
Task 2. Define guidelines for required tobacco control prompts in participating partner EHR systems.	Complete
Task 3. Review and adopt Million Hearts Action Guide "Identifying and Treating Patients Who Use Tobacco."	Complete

Task 4. Implement the Million Hearts Action Guide "Identifying and Treating Patients Who Use Tobacco."	9/30/2017
Task 5. Utilizing AAFP's tool "Integrating Tobacco Cessation Into Electronic Health Records" support partners to customize their EHR systems to prompt clinical teams to use the 5 A's of tobacco control approach to assist their patients.	6/30/2017
Task 6.Demonstrate the ability to prompt providers to complete the 5A's of tobacco control in EMR and develop and implement workflow that ensures providers are completing the 5A's of tobacco control for all applicable patients.	6/30/2017
Task 7.PCP Partners to provide PHI-blinded screenshots demonstrating the completion of the 5A's of tobacco control for 10 unique patients, or the maximum number of patients that are eligible.	6/30/2017
Task 8. Train staff to incorporate the workflow for completion and documentation of the 5 A's of tobacco control.	6/30/2017
Metric 2. PPS provides periodic training to staff to incorporate the use of EHR to prompt the use of 5 A's of tobacco control.	9/30/2017
Task 1. Utilizing AAFP's "Integrating Tobacco Cessation Into Electronic Health Records" resources train participating primary care teams about using the EHR to document the 5 A's of tobacco control.	6/30/2017
Task 3. Monitor and track training of the 5A's utilizing the PPS' learning management system.	9/30/2017
4. (Formerly Milestone 9) Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	9/30/2017
Metric 1. PPS has protocols in place to ensure blood pressure measurements are taken correctly with the correct equipment.	9/30/2017
Task 1. Utilizing Million Hearts Action Guide, "Hypertension Control - Change Package for Clinicians" , identify and adopt best practices for taking accurate blood pressure measurements at all participating practitioner sites.	9/30/2017
Task 2. Evaluate current workflows, and implement new processes supported by protocols and appropriate staff training on accurate blood pressure measurement and documentation by applicable staff.	9/30/2017
Task 3. Assure ongoing staff competencies for accurate measurement of blood pressure by direct observation, frequent assessment, and training.	9/30/2017
5. (Formerly Milestone 10) Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a visit.	9/30/2017

Metric 1. Implement PPS a patient stratification system to identify patients who have repeated elevated blood pressure but no diagnosis of hypertension.	9/30/2017
Task 1. TDMC will survey participating providers to assess system capabilities and processes regarding BP measurement. Survey results will inform the PMO regarding the feasibility of patient registries by site that can identify and stratify patients who have repeated elevated blood pressure readings but do not have a diagnosis of hypertension.	Complete
Task 2. Develop and implement protocols and appropriate tools to identify and proactively reach out to patients with the following conditions to bring them into care : 1. Two or more elevated blood pressure readings in the past year with no diagnosis of hypertension 2. An abnormal blood pressure reading as defined by HEDIS criteria without a visit in the past six months	9/30/2017
Task 3. Train staff to ensure effective patient identification and appropriate visit scheduling.	9/30/2017
Task 4. Demonstrate the ability to generate a lists of patients with elevated blood pressure readings who do not have a diagnosis of hypertension	9/30/2017
Task 5. Obtain baseline reports from participating practices on the percentage of who have repeated elevated blood pressure but no diagnosis of hypertension.	9/30/2017
Metric 2. PPS has implemented an automated or work driver scheduling system to facilitate scheduling of targeted hypertension patients.	9/30/2017
Task 1. Provide support for the development and/or update of Clinical Decision Support Systems (CDSS) in EHR systems across the PPS to prompt staff to schedule targeted hypertension patients for follow up.	Complete
Task 2. The EHR Subcommittee provides support for the implementation and/or update of Clinical Decision Support Systems (CDSS) in EHR systems across the PPS to prompt staff to schedule targeted hypertension patients for follow up.	9/30/2017
Task 3. Assure the completion of staff training at the practice level to make effective use of the new CDSS features in EHR.	9/30/2017
Task 4. Define guidelines for required hypertension control prompts in participating partner EHR systems.	Complete
Task 5. Develop and implement workflow changes and protocols necessary for a population-health approach to schedule appointments for eligible patients by utilizing gap lists from EHRs and assigning staff for regularly scheduled outreach activities.	9/30/2017

Metric 3. PPS provides periodic training to staff to ensure effective patient identification and hypertension visit scheduling.	9/30/2017
Task 1. Provide periodic staff training and feedback at the practice level to reinforce the importance of the use of the Clinical Decision Support System features in EHR to identify and schedule patients who need a hypertension visit.	9/30/2017
Task 2. Assure staff training on new workflow changes and protocols for utilizing gap lists from EHRs to conduct regular outreach to targeted hypertension patients for scheduling follow-up appointments.	9/30/2017
6. (Formerly Milestone 11) Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	9/30/2017
Metric 1. PPS has protocols in place for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiating factors.	9/30/2017
Task 1. Project subcommittee, in collaboration with hypertension specialists, will develop clinical algorithms for medication management of hypertension with particular emphasis on once-daily regimens or fixed-dose combination pills when appropriate.	Complete
Task 2. CQAC will review and approve the clinical algorithm for medication management.	Complete
Task 3. Clinical leaders at participating practices will assume responsibilities for implementation of medication management guidelines at their facilities. When medication regimens are modified, adherence is reassessed to determine patient compliance.	6/30/2017
Task 4. Monitor that once daily regimens or fixed combination pills are prescribed when appropriate through periodic review of a sample of de-identified screenshots of the prescribed regimes in the EHR.	6/30/2017
7. (Formerly Milestone 14) Develop and implement protocols from home blood pressure monitoring with follow up support.	9/30/2017
Metric 1. PPS has developed and implemented protocols for home blood pressure monitoring.	9/30/2017
Task 1. Adopt and implement tools and protocols from the AMA / Johns Hopkins program, "Self-measured blood pressure monitoring program: Engaging patients in self-measurement" for the implementation of home blood pressure monitoring with follow-up support for appropriate patients identified by clinicians across the participating practitioner organizations.	9/30/2017

Task 2. Incentivize participating practices to support implementation of protocols for home blood pressure monitoring with follow up support.	9/30/2017
Task 3. The CQAC and Clinical leaders will identify a pilot location and implement protocols to provide appropriate follow-up clinical support for patients who self-monitor their blood pressure.	9/30/2017
Task 4. Staff will be identified and trained on how patients should be taught to self-monitor their blood pressure.	9/30/2017
Task 5. Based on the success of the pilot, protocols will be rolled-out to participating providers for implementation of appropriate follow-up clinical support for patients who self-monitor their blood pressure.	9/30/2017
Metric 2. PPS provides follow up to support to patients with ongoing blood pressure monitoring, including equipment evaluation and follow-up if blood pressure results are abnormal.	9/30/2017
Task 1. Assist participating practitioners in identifying the appropriate type/s of follow-up clinical support to support their patients who self-monitor their blood pressure.	9/30/2017
Task 2. Assist participating practitioners to identify support staff resources who can teach patients how to use monitors, validate devices, and review action plans and blood pressure logs.	9/30/2017
Task 3. Assist participating practices to train patients to report any abnormal readings back to the site team member for appropriate assistance	9/30/2017
Task 4. Assure completion of home blood pressure documentation in structured fields within the EHR.	9/30/2017
Metric 3. PPS provides periodic training to staff on warm referral and follow-up process.	6/30/2017
Task 1. Develop "warm referral" protocol and annual clinician and staff training at the participating practice level on the new protocol and active tracking.	Complete
Task 2. Provide training on a periodic basis to appropriate clinical and non-clinical staff across the PPS.	Complete
8. (Formerly Milestone 15) Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	9/30/2017
Metric 1. PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.	9/30/2017
Task 1. Develop and adopt guidelines for establishing EHR structured fields and registry criteria to generate periodic lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	6/30/2017

Task 2. The EHR Subcommittee provides support for the implementation and/or update of Clinical Decision Support Systems (CDSS) in EHR systems across the PPS to prompt staff to schedule targeted hypertension patients for follow up.	9/30/2017
Task 3. Develop and implement workflow changes and protocols necessary for a population-health approach to schedule appointments for eligible patients by utilizing gap lists from EHRs and assigning staff for regularly scheduled outreach activities.	9/30/2017
Task 4. Assure completion of staff training at the practice level to make effective use of the new CDSS features in EHR.	9/30/2017
Task 5. Monitor effectiveness of the processes by obtaining quarterly data from participating practices on percentage of eligible patients who were scheduled for a follow-up visit	9/30/2017
9. (Formerly Milestone 16) Facilitate referrals to NYS Smoker's Quit Line.	9/30/2017
Metric 1. PPS has developed referral and follow-up policies and procedures.	9/30/2017
Task 1. Review and adopt Million Hearts Action Guide "Identifying and Treating Patients Who Use Tobacco."	Complete
Task 2. Implement the Million Hearts Action Guide "Identifying and Treating Patients Who Use Tobacco."	9/30/2017
Task 3. Implement the 5A's of tobacco control and utilize EHR to prompt practicing providers.	6/30/2017
Task 4. Utilizing the AAFP evidence-based guidelines "Treating Tobacco Dependence Practice Manual", develop and implement process to refer identified patients to NYS Smoker's Quitline.	9/30/2017
Task 5. Utilize the EHR to document and track referrals to NYS Smoker's Quitline and provide follow up as appropriate.	9/30/2017
Task 6. Provide a roster of de-identified unique patients that were referred to the Quitline using the referral process.	9/30/2017
10. (Formerly Milestone 18) Adopt strategies from the Million Hearts Campaign.	9/30/2017

Metric 1. Providers can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts campaign.	9/30/2017
Task 1. Adopt and implement policies and procedures from Million Hearts Campaign, including the Hypertension Change Package, as new protocols are developed to support the implementation of project clinical milestones	9/30/2017
Task 2. Adopt, follow, and implement standardized treatment protocols that align with the national JNC 8 guidelines and medication management algorithm for the treatment of Hypertension and train applicable staff on the guidelines.	Complete
Task 3. Adopt, follow, and implement standardized treatment protocols that align with the 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults for the treatment of Cholesterol Management and train applicable staff on the guidelines.	Complete
Task 4. Utilizing Million Hearts Action Guide, "Hypertension Control - Change Package for Clinicians" , identify and adopt best practices for taking accurate blood pressure measurements at all participating practitioner sites.	6/30/2017
Task 5. Adopt and implement tools and protocols from the AMA / Johns Hopkins program, "Self-measured blood pressure monitoring program: Engaging patients in self-measurement" for the implementation of home blood pressure monitoring with follow-up support for appropriate patients identified by clinicians across the participating practitioner organizations.	9/30/2017
Task 6. Monitor effectiveness of tobacco use screening, cessation interventions including referrals to NYS Smokers Quitline and treatment.	9/30/2017
Task 7. Review and adopt Million Hearts Action Guide "Identifying and Treating Patients Who Use Tobacco."	Complete
Task 8. Implement the Million Hearts Action Guide "Identifying and Treating Patients Who Use Tobacco."	9/30/2017
Task 9. Develop and implement process at participating practices to: 1. Identify patients that are eligible for aspirin regimen based on HEDIS criteria 2. Educate and counsel eligible patients on benefits of aspirin regimen 3. Prescribe aspirin regimen to eligible patients	9/30/2017
11. (Formerly Milestone 20) Engage a majority (at least 80%) of primary care providers in this project.	9/30/2017
Metric 1. PPS has engaged at least 80% of their PCPs in this activity.	9/30/2017

Task 1. Establish contractual agreements with participating primary care organizations to assure engagement of at least 80% of their primary care practitioners in this project.	9/30/2017
Task 2. Track primary care practitioner engagement on committees to ensure that 80% of contracted PCPs are represented.	9/30/2017

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

Mid-Point Assessment Recommendation #1:	The IA recommends that the PPS develop a corrective a complete the project requirements that the IA determi PPS Speed & Scale commitment date for this project. Th timeline for the completion of the three project require by DY2, Q2 as part of this action plan.

PPS Defined Milestones/Tasks
1. Implement evidence-based asthma management guidelines between primary care practitioners, specialists, and community-based asthma programs (e.g., NYS Regional Asthma Coalitions) to ensure a regional population based approach to asthma management.
Metric: PPS has agreements from participating providers and community programs to support a evidence-based asthma management guidelines.
Metric: All participating practices have a Clinical Interoperability System in place for all participating providers.
M1:1. Identify key stakeholders and participating provider organizations critical for successful project implementation.
M1:2. Create a PPS-wide project sub-committee with representation from key stakeholders to oversee the project implementation.
M1:3. Collaborate and form agreements with overlapping PPSs (i.e. Alliance for Better Health Care will be implementing 3.d.ii), Asthma Coalition of the Capital Region, and other stakeholders to align initiatives to support the guideline-concordant care.
M1:4. Survey key stakeholders to assess current use and adherence to guideline-concordant care Expert Panel Review-3 (EPR-3) guidelines, range of services provided, and referral mechanisms.
M1:5. Develop, working in collaboration with the project sub-committee and clinical experts across the PPS, a draft document defining the future state for the management of asthma utilizing evidence-based strategies.
M1:6. Submit the draft future state document to Clinical and Quality Affairs committee for review and approval.
M1:7. Execute written contracts with participating providers implementation of asthma guidelines.
M1:8. Develop and adopt protocols that ensure providers are prescribing preferred formulary asthma controller medications to persistent and poorly controlled asthmatic patients

M1:9. Track rate of asthma controller medications prescribed to persistent and poorly controlled asthmatics.
M1:10. At one of the participation primary care practices, pilot a performance improvement project designed to improve rate of asthma controller medications prescribed to persistent and poorly controlled asthmatics.
M1:11. Track Asthma Control Test for at least 3 months.
M1:12. At one of the participating primary care practices, pilot a performance improvement project designed to increase the rate of Asthma Control Test utilization.
M1:13. Adopt and implement minimum requirements of asthma pathways best practice guidelines in the Emergency Department.
M1:14. Adopt and implement protocols to refer persistent and poorly controlled asthmatics to home-based intervention services upon discharge from ED or inpatient stay.
M1:15. Provide formal asthma education to persistent and poorly controlled asthmatics or develop protocols to refer persistent and poorly controlled asthmatics to community educator, home based medication support or other appropriate community resource for asthma education.
M2:1. Establish, under the auspices of the AMCH PPS Technology and Data Management Committee (TDMC), an ad- hoc project sub-committee to oversee the development and implementation of the action plan to assure PPS-wide EHR connectivity to the SHIN-NY and HIEs. Ensure key representation from
M1:2. Perform a current state assessment on the participating provider organizations' EHR systems' features and capabilities for connectivity to SHIN-NY and HIXNY.
M2:3. Utilizing the IT-TOM pilot experience, design the PPS- wide future state connectivity model.
M2:4. Complete a gap-analysis utilizing the current state assessment and defined future state, creating an implementation plan and a phased roll-out.
M2:5. Update the current state assessment and defined future state for all contracted partners, creating an updated implementation plan and a phased roll-out for contracted partners requiring connectivity.
M2:7. All RHIO eligible contracted partners have signed Hixny QE and DSRIP Hixny One-To-One Exchange Agreements and connectivity has been established with Hixny (RHIO) that meets minimum requirements as defined by PPS.
M2:6. Work with participating providers, not currently connected to a RHIO, to pursue Data Exchange Incentive Program (DEIP) opportunities to fund RHIO connectivity costs
M2:8. Monitor progress on the ability to share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look-up, and support timely care management decisions.

2. Establish agreements to adhere to national guidelines for asthma management and protocols for access to asthma specialists, including EHR-HIE connectivity and telemedicine.
Metric: Agreements with asthma specialists and asthma educators are established.
Metric: EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.
Metric: Telemedicine service implemented, based on evaluation of impact to underserved areas including, but not limited to:- analysis of the availability of broadband access in the geographic area being served- gaps in services- geographic areas where PPS lacks resources and telemedicine will be used to increase the
M1:1. Create a list of participating asthma and allergy specialists in the PPS network who serve the targeted patient populations.
M1:2. Form co-management agreements with asthma specialists and asthma educators to provide a framework for better communication and safe transition of care, as well as optimal health care, consistent with national guidelines for asthma patients.
M1:3. Establish appropriate contractual agreements with regional asthma specialists, including the Asthma Coalition of the Capital Region, to support a comprehensive, coordinated and patient-centered asthma care plan in the community, including training and development of practice based asthma educators.
M2:1. Establish, under the auspices of the AMCH PPS Technology and Data Management Committee (TDMC), an ad- hoc project sub-committee to oversee the development and implementation of the action plan to assure PPS-wide EHR connectivity to the SHIN-NY and HIEs. Ensure key representation from
M1:2. Perform a current state assessment on the participating provider organizations' EHR systems' features and capabilities for connectivity to SHIN-NY and HIXNY.
M2:3. Utilizing the IT-TOM pilot experience, design the PPS- wide future state connectivity model.
M2:4. Complete a gap-analysis utilizing the current state assessment and defined future state, creating an implementation plan and a phased roll-out.
M2:5. Update the current state assessment and defined future state for all contracted partners, creating an updated implementation plan and a phased roll-out for contracted partners requiring connectivity.
M2:7. All RHIO eligible contracted partners have signed Hixny QE and DSRIP Hixny One-To-One Exchange Agreements and connectivity has been established with Hixny (RHIO) that meets minimum requirements as defined by PPS.
M2:6. Work with participating providers, not currently connected to a RHIO, to pursue Data Exchange Incentive Program (DEIP) opportunities to fund RHIO connectivity costs
M2:8. Monitor progress on the ability to share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look-up, and support timely care management decisions.

M3:1. Evaluate the availability of broadband access in the geographic area being served.
M3:2. Meet with Albany Medical Center Faculty Practice and Columbia Memorial Leadership to discuss feasibility; Establish PPS workgroup with PMO representation, specialist group representation and PCP representation
M3:3. Based on the results of the evaluation, the two sub-committees will develop a draft telemedicine implementation plan that will include a vendor selection process if necessary. The draft document will be reviewed and approved by CQAC and the TDMC.
M3:4. Identify one primary care practice for piloting the ECHO model to connect with a specialist at AMCH.
M3:5. Train identified workgroup members on Project ECHO replication for the AMCH PPS. This training is held in New Mexico.
M3:6. Hold three sessions through the Project ECHO platform.
M3:7. Identify eligible funds to support implementation costs of Project ECHO.

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Target Completion Date
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Mid-Point Assessment Recommendation #5:	
PPS Defined Milestones/Tasks	***Target Cor***
1. Engage Community Based Organizations in projects and workstreams	
1. Continue ongoing CBO engagement mechanisms such as the Consumer and Community Affairs Committee, Cultural Competency and Health Literacy Committee, and the 2di Patient Activation Measure workgroup.	
2. Conduct face to face meetings with representatives from NYSDOH identified Tier 1 CBOs to identify community and gaps in services	
3. Collaborate with S2AY Rural Health Network to identify technical assistance needs of CBOs	
4. Educate CBOs on other resources and subcontracting opportunities pertaining to DSRIP	
5. Issue RFPs for Consumer Listening Session addressing preventative care services	
6. Facilitate 4 Networking/collaboration events with CBOs in the 5 county catchment area	
2. Execute ongoing contracts with Community Based Organizations	
1. Execute Business Associate Agreements and Partner Organization Agreements with NYSDOH identified Tier 1 CBOs and other community/neighborhood CBOs that are not already contracted but are actively participating in events, committee meetings, and best practice sharing.	
2. Collaborate with Tier 1 CBOs to identify resources and services that align with PPS projects	
3. Provide Phase II contract metrics to CBOs within the AMCH PPS to participate in all projects in which a CBO has interest and can provide appropriate services	
4. Work collaboratively with CBOs providing care management services to effectively create a centralized care management system. This system will contract with existing CBOs to provide services to attributed patients	

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9/31/2017

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

Mid-Point Assessment Recommendation #1: The IA recommends that the PPS develop an action plan to impler
PPS Defined Milestones/Tasks
1. Implement Introductory to Cultural Competency and Health Literacy Training.
1. Conduct webinar-based Intro to CCHL training to primary contacts and Cultural Competency/Health Literacy (CC/HL) Champions.
2. Complete post-training assessments and course evaluation to understand partners' preference on disseminating this training to larger audience in their organizations. Share the results with partners.
3. Meet with individual CCHL Champions to discuss organization-specific action steps for disseminating this training information in their own organizations.
2. Implement 2-day Bridges Out of Poverty training.
1. Conduct partner surveys to gather their preference and priorities in CCHL training areas.
2. Identify trainers and location for the first session.
3. Complete first session with pre/post-training assessments and evaluation.
4. Identify dates and location for the second session. Incorporate feedback from evaluation as necessary.
5. Complete second session with pre/post-training assessments and evaluation.
6. Identify dates and location for the third session. Incorporate feedback from evaluation as necessary.
7. Complete third session with pre/post-training assessments and evaluation.
3. Disseminate HealthStream licenses to partners with contents uploaded.
1. Complete pilot of self-registration process for HealthStream with PMO staff to identify any barriers for partners navigating the process.
2. Identify internal process to manage HealthStream licenses and priority audiences for license distribution. Look for opportunities for collaboration with Alliance for Better Health Care and Adirondack Health Institute to target audiences most effectively.
3. Identify priority content area(s) for CCHL training based on partners' feedback and comments from Consumer Listening Sessions.
4. Identify content expert(s) based on feedback from Cultural Competency & Health Literacy Committee (CCHLC), CC/HL Champions and other partners.
5. Develop and upload contents (including pre-/post-training assessments) to HealthStream. Have files available for partners who already have other forms of Learning Management Systems.
6. Distribute licenses to partners and open self-registrations for target audiences.
7. Track users for training completion and their assessment scores. Gather continuous feedback from partners to identify additional content areas to develop and upload on HealthStream.
4. Establish CC/HL Champion meetings to bring educational topics for discussions and networking opportunities.

1. Host 4th CC/HL Champion meeting with two speakers to discuss health literacy and LGBTQ-related issues.
2. Host at least one joint CC/HL Champions training with Alliance for Better Health Care and Adirondack Health Institute.
3. Continue to host quarterly CC/HL Champion meeting with a speaker. Identify topic and speaker based on partners' interest and feedback.
5. Co-host Health Literacy Symposium with Alliance for Better Health Care PPS to spark interest about health literacy among clinicians and frontline care providers.
1. Identify a speaker with content expertise in health literacy.
2. Decide date and time of the event as well as the content of the symposium. Incorporate partners' feedback as necessary.
3. Complete Continuing Medical Education (CME) application.
4. Secure venue, speaker and other necessary services through contracting processes.
5. Begin publicity to partners in both PPSs to fill 200 seats.
6. Complete event with pre- and post-activity assessments. Record event for future viewing.
7. Conduct follow-up survey one month after the event to measure changes in competency.
8. Compile post conference packets for submission to CME office.

ment its CCHL trainings to partners.
Target Completion Date
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4/23/2017
5/4/2017

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Mid-Point Assessment Action Plan - Implementation Plan

PPS Defined Milestones/Tasks
1. Expand primary care capacity to ensure the provision of required services.
1. Pending receipt of Statewide Health Care Facility Transformation Program grant for Albany Medical Center Hospital, finalize facility planning, contract agreement and CON, if needed.
2. Finalize proposal of Transitional Care Clinic for review by Albany Medical Center Leadership
3. Receive decision on Transitional Care Clinic from Albany Medical Center leadership.
4. Meet with CPC+ eligible practices to assess needs for meeting CPC+ requirements.
5. Collaborate with CPC+ primary care practices to align DSRIP related system transformation activities with transformation activities necessary to achieve CPC+ objectives.
6. Meet with organizations that received Capital Restructuring Finance Program (CRFP) to discuss collaboration in grant implementation.
7. Outline steps to support integration of behavioral health services at primary care sites in Columbia Memorial Health as part of CRFP implementation.
8. Outline steps to support integration of primary care in proposed crisis stabilization program administered by Northern Rivers Family of Services as part of CRFP implementation.
9. Meet with Albany County Department of Mental Health to assess needs for embedding primary care into behavioral health.
10. Meet with primary care leadership to explore feasibility of partnership for providing primary care services at Albany County Department of Mental Health sites.
11. Based on a proposal submitted by Addiction Care Center of Albany, evaluate feasibility of supporting integration of primary care and behavioral health.
12. Finalize action plan for supporting integration of primary care and behavioral health at Addition Care Center of Albany.
13. Link Koinonia Primary Care to Montefiore Care Management Organization's Evaluation of a Continuum Based Framework for Behavioral Health Integration amongst Small Primary Care Practices and provide ongoing technical assistance.
14. Reach out and engage primary care practices to participate in appropriate primary care-related projects and align financial incentives for project participation.
15. Develop Recruitment and Retention Fund based on Adirondack Health Institute's model. Determine fund allocation.
16. Distribute Recruitment and Retention Fund to partners based on approval.
17. Meet with Albany Medical Center Faculty Practice and Columbia Memorial Leadership to discuss next steps in implementing evidence-based telemedicine program, Project ECHO, to link primary care practitioners with specialists at Albany Medical Center.

18. Identify one primary care practice for piloting the Project ECHO model to connect with a specialist at AMCH.
19. Hold three sessions through the Project ECHO platform.
20. Incentivize participating practices to support implementation of protocols for home blood pressure monitoring with follow-up support.
21. Incentivize development and adoption of policies and procedures for follow-up blood pressure checks without a copayment or advanced appointment.
2. Work with primary care at the practice level to support them in successfully achieving PCMH/APC and ensure that existing statewide resources for technical assistance are being leveraged appropriately
1. Establish a project sub-committee with representation from all participating primary care practitioners to facilitate and assure achievement of 2014 NCQA Level 3 PCMH recognition or APCM by DY3.
2. Implement training sessions for senior leaders, clinicians and staff to learn about the benefits of achieving 2014 NCQA Level 3 PCMH recognition or APCM.
3. Working in collaboration with HANYS Practice solutions, perform a current state assessment of participating practices' capabilities to provide patient-centered care consistent with the NCQA 2014 Level 3
4. Perform a practice-specific gap analysis to determine the needed financial, technical and operational support needed to assure successful recognition by DY3.
5. Based on the gap analysis, establish priorities and develop a practice specific action plan to achieve the recognition and transform the care delivery model.
6. Create a learning collaborative for participating safety-net providers to assist in the development of necessary workflows and other changes to become NCQA Level 3 certified or APCM.
7. Assign specific roles and responsibilities for the participating practice leadership and timelines to implement the action plan effectively and achieve the recognition by DY3.
8. Working in collaboration with HANYS Practice Solutions, monitor progress on a monthly basis to evaluate progress and assess needed additional resources to support practice transformation.
9. Designate staff at participating primary care sites as contacts for ED care coordinators/patient navigators for access and care coordination needs.
10. Implement protocols to assure timely access and effective communication for care transitions between ED and community primary care practices.
11. All contracted PCPs, and Care Coordinators subscribe to Hixny-Generated alerts and develop protocols to follow-up with patients discharged from the hospital/ED within 48-72 hours of discharge
3. Ensure primary care plays a central role in a integrated delivery system; primary care is represented in governance committees and structure and clinical quality committees
1. Contracted PCPs have connected to HIXNY and actively share data.
2. Establish Primary Care Advisory Group to seek guidance and input on PPS's direction for supporting primary care system.
3. Determine regular meeting schedule for Primary Care Advisory Group.
4. AMCH PPS governance structure reflects primary care involvement in decision making. Primary care is represented in PAC Leadership, Board and committees/subcommittees.

5. Have on-site meeting with frontline clinicians from at least one primary care practice to discuss benefits and challenges of workflows that are implemented as part of DSRIP.
6. Finalize contracts with Health Home care management agencies to support primary care practices in community-based care management services.
7. Finalize agreements and establish BHNNY Cares.
4. Enable primary care to participate effectively in value-based payments
1. Conduct a comprehensive baseline survey that includes questions related to VBP.
2. Complete assessment of all funded partners on their current state of VBP contracts, education and technical/data needs, perceived barriers to success and preferred VBP compensation modalities.
3. Establish VBP Workgroup that includes primary care representation.
4. Have partners participate in the Region 1 VBP boot camps hosted by the State.
5. Develop Phase 2 contract metrics to focus on transition towards VBP.
6. Host VBP education sessions partners including primary care physicians
5. Develop funds flow to support AMCH PPS's primary care strategies
1. Develop phase 1 contract metrics to incentivize reporting and engagement in DSRIP activities.
2. Develop phase 2 contract metrics to allocate funds to support PCP partners. Include clinical and primary care leaders in phase 2 contract metric development.
6. Make progress toward integrating Primary Care and Behavioral Health
1. Conduct a current state assessment of primary care and behavioral health organizations about their current capacity and processes.
2. Establish Behavioral Health Quality Improvement Subcommittee under the auspices of the Clinical Quality Affairs Committee to support behavioral health quality improvement initiatives including those related to the integration of primary care and behavioral health services and increasing screening rates for depression.
3. CQAC approves the recommendations for preventative care behavioral health depression screenings for adults and adolescents and evidence-based standards of care for management of depression and ADHD in primary care.
4. Identify interested organizations that are able to furnish primary care and behavioral health providers for integration into other organizations.
5. Facilitate collaboration between partners with varying degrees of experience in integrating primary care and behavioral health services.
7. Outline steps to support integration of behavioral health services at primary care sites in Columbia Memorial Health as part of CRFP implementation.
7. Link Koinonia Primary Care to Montefiore Care Management Organization's Evaluation of a Continuum Based Framework for Behavioral Health Integration amongst Small Primary Care Practices and provide ongoing technical assistance.
8. Identify a range of quality improvement activities related to the integration of behavioral health and primary care services and align incentives.

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