Alliance for Better Health Care, LLC, ("Alliance") is committed to improving the health of our most vulnerable populations. We agree with the IA's overall assessment that Alliance has made positive strides to develop the infrastructure to run a successful PPS in our six-county wide region of Upstate NY.

The IA raised a number of issues, and identified a series of specific recommendations.

Issues:

PMO spending: Alliance's Project Management Office (PMO) distributions compare very favorably to the statewide average for all PPS PMO distributions. Alliance's spending on its PMO was only 15% of all DSRIP funds allocated, compared to a statewide average of all PPSs of 42%. As a true start-up Alliance has invested appropriately to cover administrative costs. These front loaded investments make sense and the result is an organization built end-to-end for the express purpose of DSRIP. We believe this singularity of focus will add significant value over the life of the program.

Partner engagement in the governance process: The active participation of our five owners, as well as the fifteen representatives who serve on our Board of Managers, (inclusive of a representative from our PAC, two independent practitioners, and a County Commissioner of Mental Health), and close to fifty different partners who serve on one or more governance committees illustrates Alliance's commitment to partner engagement throughout our governance structure.

Partner engagement on the projects: When assessing partner engagement in the projects it is important to recognize that the Provider Import Tool ("PIT"), from which the number of engaged partners was determined, has structural limitations which result in significantly undercounting engagement. For instance, the PIT captures only those partners with whom Alliance has a signed contract. So, in the instance of a participating practice group under contract, the PIT would reflect only one PCP actively engaged (the practice signatory and authorized recipient of allocated funds), when in fact dozens of PCP providers of that practice may be actively engaged and will share in those funds.

Timing is another important consideration: The IA's assessment reflected only those partners in the PIT who had a signed contract and were receiving funding as of September 30, 2016. However, since that cut-off date, Alliance has completed contracting with dozens of additional partners, representing a diverse set of provider types, resulting in the distribution of an additional $26,000,000. This is inclusive of an increase in DSRIP funds distributed by Alliance to CBOs of $3.8M since September 3oth, for a total allocation to CBOs of $4.6M to date (which equates to over 13% of all allocated funds).

Additionally, the filing date of Alliance's detailed Primary Care Plan (11/2/2016), CBO engagement strategy (01/31/2017), and Workforce training strategy (01/31/2017), precluded the IA from integrating an analysis of these plans into the Mid-Point Assessment report.

Patient Engagement: The IA relied on reported project specific patient engagement as a component of their overall project assessments. Here it is important to recognize that Alliance set stretch objectives for patient engagement. An alternative approach, employed by other PPSs, was to set very conservative patient engagement objectives maximizing the opportunity to "make the number" but not necessarily maximize patient engagement. Therefore, a black and white assessment of achieving patient engagement commitments is potentially misleading. Even with these stretch objectives Alliance has continued to improve patient engagement results quarter over quarter. Currently, Alliance is trending favorably towards meeting the respective commitments for 5 of 8 projects by the end of DY2, and will

report thousands of engaged patients across the three projects where the stretch objective is not reached.

Recommendations:

Organizational			
Partner Engagement			
	R1	The IA requires the PPS to develop an action plan to increase partner engagement, in particular for PCPs and Behavioral Health partners.	The IA report, because of timing, did not reflect the detailed action plan included within the Primary Care Plan for increasing partner engagement focusing on PCPs and Behavioral Health partners submitted by Alliance. Alliance respectfully requests that the IA review that PPS Primary Care Plan, submitted 11/2/2016, and attached again here, in response to partner engagement recommendation 1. Additionally, Significant contracting that has taken place subsequent to 9/30/2016, resulting in an additional $26,000,000 in DSRIP funds being allocated to Alliance partners. Again, because of timing, the associated partner engagement would not have been reflected in the IA report. Finally, PIT has certain technical limitations which caution against drawing conclusions about the degree of partner engagement from the PIT, regardless of the timing. For instance, for a participating practice group under contract, the PIT would reflect a count of only one PCP actively engaged (the authorized recipient of allocated funds), when in fact dozens of PCP providers of that practice may be actively engaged and will share in those funds.
Community Based Organization Contracting			

	R1	The IA recommends that the PPS develop an action plan to address the contracting with CBOs.	Alliance recognizes that Community Based Organizations (CBOs) play an important role in achieving DSRIP performance measures and will be submitting an updated matrix, reflecting an expansion of CBO contracting, as part of the DY2Q3 report "Governance Milestone # 6: Finalize partnership agreements or contracts with CBOs." Alliance and its Collaborative partners have been increasingly strategic in identifying and contracting with the CBOs that offer social supports and home and community based services. Through this process Alliance learned that not all CBOs were fully aware of importance of their involvement and that the Collaborative partners were not fully aware of services offered by the various CBOs in their community. Alliance strategy for addressing this knowledge gap includes numerous methods of outreach and education including town hall meetings, newsletters, e-learning platforms, quarterly Alliance sponsored CBO roundtables for the exchange of best-practices, and the development of a searchable database of community resources. These activities form the basis for understanding the critical role CBOs play in the transformation to community based care, and will result in a continued expansion of CBO contracting. Please note, that subsequent to the 09/30/2016 PIT submission, DSRIP funds allocated by Alliance to CBOs increased by $3.8M for a total allocation to CBOs of over $4.6M to date (which equates to over 13% of all allocated funds).
Cultural Competency and Health Literacy			
	R1	The IA recommends that the PPS develop a strategy to address how it will measure the effectiveness of	Alliance has recognized that in order to provide quality unbiased care there needs to be an understanding of the cultures and

		their CCHL outreach efforts across the PPS network.	beliefs of the community, as well as the workforce of our Collaborative partners. Alliance outreach strategy includes: evaluation of the Community Needs assessment, collection of meaningful demographic data in the EHR (for example data points of sexual orientation, race, ethnicity, preferred language and results health literacy assessment can facilitate the most appropriate care, outreach and engagement), evaluation of the workforce and determine if it reflects the population being served, workforce inclusion in development of outreach efforts and community inclusion of development of outreach efforts. Alliance has partnered with community based organizations to host listening sessions that will assist Alliance in gaining the individual's perspective on health care access. Each session will be based around 5 key areas: their ideal health care environment, If they utilize ER instead of accessing care with a PCP, how and why individuals access care, barriers to accessing care, and what resources/services that would assist them and their families to stay healthy. The outcome of the sessions will determine outreach efforts for that community. Methods to address outreach needs include Review of Communities Needs Assessment on an annual basis, annual patient satisfaction surveys, annual employee satisfaction surveys, annual review of workforce recruitment efforts and staffing needs, quarterly review of patient demographic data, minimum of 2 listening sessions during the first half of 2017 with subsequent bi-annual scheduled sessions and outcomes of patent engagement and performance measures on a quarterly basis. Tracking of the listening sessions and training needs will be monitored for effectiveness and adjusted as needed.
	R2	The IA recommends that the PPS develop a strategy to better	Alliance's approved CCHL training strategy relies on the use of an organizational specific

		address the CCHL training needs of its partners.	assessment, review of current training materials/topics and additional materials recommended by the CCHL taskforce to determine the training needs of each partners. The strategy implementation is initially with Alliance's two FQHC partners, and will continue to be rolled out to other partners. The training strategy focus it to raise awareness of the challenges of individuals that are under-resourced or struggling with behavioral health/substance use issues, improve knowledge of cultural beliefs and practices, and ensure delivery of non-judgmental, culturally and linguistically appropriate services that ultimately will improve patient engagement in health care. This approach will include two audiences 1) the individuals accessing/not accessing care and 2) health care provider and community agencies. Alliance has partnered with community based organizations to host listening sessions that will assist Alliance in gaining the individual's perspective on health care. Each session will be based around 5 key areas: their ideal health care environment, If they utilize ER instead of accessing care with a PCP, how and why individuals access care, barriers to accessing care, and what resources/services that would assist them and their families to stay healthy. The outcome of the sessions will determine additional training needs of the partners. The second audience of the training strategy is health care providers and staff in multiple settings. The training strategy is developed to fit different learning styles, workplace cultures and personal preferences. Training opportunities will include e-learning modules, live trainings, printed materials, one-to one interactions and peer to peer knowledge transfer. Methods to address training needs include: organizational assessment conducted annually, review of training materials/topics on an annually basis, pre/post testing of

			training modules, minimum of 2 listening sessions during the first half of 2017 with subsequent bi-annual scheduled sessions, Collaborative partners will submit training documentation to the CCHL/workforce committee on a quarterly basis. Tracking of the listening sessions and training needs will be monitored for effectiveness and adjusted as needed.
	R3	The IA recommends that the PPS develop metrics to assess its most effective strategies to engage Medicaid members and the uninsured.	Alliance's Community Needs Assessment provided a baseline of hot spots of Medicaid members and the uninsured population to be engaged in the patient activation project. Alliance established objectives, approved by DOH, specific to engaging Medicaid members and the uninsured. Alliance measures performance against these commitments on a quarterly basis, and has meet the associated DY1 commitments. Alliance achieved it DY2Q2 patient engagement commitment and is trending favorably towards the achievement of the associated DY2Q4 target. Methods to address the effectiveness include: a minimum of two listening sessions in each of PPS regions during the first half of 2017, patient advisory groups to begin in Q3 of 2017 with subsequent bi-annual scheduled sessions, and continue to engage PAC members on a quarterly basis, annual patient satisfaction surveys, and outcomes of patent engagement and performance measures on a quarterly basis. Tracking of listening sessions and patient engagement efforts will be monitored for effectiveness of change and adjusted as needed.
Financial Sustainability and VBP			
	R1	The IA requires the PPS to assess the status of its network partner's involvement in VBP.	Alliance conducted a survey of its network partner's involvement in VBP arrangements. This survey was completed in

			September 2015. However, it has not been submitted as DOH has put this Milestone on-hold until further notice. On a separate track, DOH conducted a baseline survey of Managed Care Organizations published on 6/28/16, with the following results for the Northeast Region: of $584 million spent on mainstream managed care, nearly 74% was paid under Fee For Service (FFS) and over 24% was in VBP Level 0 arrangements. Other Levels of VBP Arrangement s reported were as follows: 0.4% was paid at VBP Level 1, 0.0% at VBP Level 2 and 1.3% at VBP Level 3. These findings track with Alliance's September 2015 survey. Alliance plans to pro-actively update the findings of its September 2015 survey in anticipation of DOH establishing a new due date for the associated Milestone in the future.
	R2	The IA requires that the PPS establish a plan to further educate and support their partners move towards VBP arrangements.	Alliance will continue to engage its partner organizations to provide education and support VBP arrangements. To date, educational sessions have been conducted with the Board of Directors of Whitney Young Health Center and a VBP educational session was conducted with the CEO of Hometown Health Centers. Alliance will provide VBP educational outreach over the next four-six months to its engaged partners to support a working understanding of VBP concepts and the necessity to move to alternative payment arrangements, leveraging partners who are actively engaged in these type of arrangements presently, e.g., Capital Care Medical Group and CDPHP are in a Level 2 arrangement.
2.b.iii ED care triage			
	R1	The IA recommends the PPS develop a training strategy to address the patient lack of knowledge regarding the shift to primary and preventive care away from the ED.	Alliance has recognized that patients who frequent the Emergency Department (ED) may have various reasons and barriers that influence their reasons to use the ED versus establishing themselves with a primary care provider. Some of these barriers may include convenience, availability of appointments and

			a potential knowledge deficit regarding the importance of care consistency, preventive and primary care. Additionally Alliance has recognized the need to reinforce with the PPS stakeholders, health care providers and community service agencies the positive influence they can have on system transformation by supporting patients as they establish a health care relationship and maintain their connection to primary care services, improving health quality, outcomes and cost. Alliance continues to support our training strategy focusing on a campaign that includes preventive health and continuity of care importance. This approach will target two audiences: 1) the patient and 2) stakeholders, health care providers and community agencies. The patient education strategy will include a minimum of two patient listening sessions during the first half of 2017 with subsequent bi-annual scheduled sessions to identify and address reasons why a patient may continue to use the ED vs. primary care. Another component of the strategy will be the roll out of patient information materials including handouts, flyers, posters, pamphlets and other culturally appropriate patient education materials to be used in various settings, slated to begin DY2Q4. The second audience will focus on health care provider education in multiple settings. The training strategy is developed to fit different learning styles, workplace cultures and personal preferences. Training opportunities will include online/WebEx modules, live trainings, peer to peer knowledge transference, one-on-one interactions and other training opportunities The strategy also includes curriculum onboarding development for the patient navigator positions using evidence based practice guidelines and learning management system (LMS) course content development on subjects such as care coordination and preventive care. Collaborative monthly progress reporting on

			training opportunities will be an agenda item at Alliance workgroups. Tracking of training sessions for both audiences will be monitored for effectiveness of change and adjusted as needed. Trainings for both audiences will be tracked on a PPS level, and also on a collaborative level within the organization.
2.b.iv Care transitions			
	R1	The IA recommends the PPS develop a strategy to centralize the approach it is taking across the network to address care transitions and include behavioral health and psychosocial issues.	Alliance continues to support its strategy to cohesively approach care transitions across the continuum while integrating behavioral health and psychosocial issues. The PPS is the central driver of our partners and collaborators, and has developed a systematic approach which the PPS will continue to execute in DY3, 4 and 5. Components of the strategy are: Drive our partners to implement evidenced based best practice tools such as high risk readmission screens, health literacy assessments tools, early warning identification processes for change in conditions and SBART communication tools to make sure smooth transitions of care occur across care settings. Progress reports regarding implementation will be discussed at least monthly at PPS central project workgroup meetings and quarterly at CI and Q committee. Identified barriers/gaps/lag in progress will be presented as action items at least monthly as part of the Care Coordination agenda items our Clinical Integration and Quality Committee meeting. Bi-directional avenues for communication will ensure all collaborators and participants in this project receive feedback and actionable items following CI and Q discussion. Require partner Hospitals/health systems to actively engage with key community agencies to develop workflows and referral processes to move effectively serve our vulnerable populations. Tracking of community agency

			involvement with be done at least quarterly, with anticipated increase in community agencies engagement in first and second half of DY3. Establish Hospital on-site presence by our community partners, to facilitate following the patient back out into the community with plan to have on site community presence at a minimum of half of the PPS participating hospital sites second quarter of 2017. Deliver training to our community partners on the use of Interact like principles during 1st quarter of 2017. Implement Patient Education Tools (Zone Sheets) in 2017 to reinforce patient post hospital D/C plans in order to reduce unnecessary readmissions. Offer Alliance sponsored IT solutions for capturing needed data for patient engagement. IT roll out to commence early 2017. Implement an IT Care Management platform and secure messaging service that will enable real time communication to the network partners as well facilitate sharing of a patient's plan of care across the continuum. Care Connects (real time secure messaging service) went live 12/8/2016 at Alliance and will next be rolled out to the partners. Coordinate with other Alliance project specific workgroups to insure that evidence based, best practice care transitions tools and practices are hardwired into Behavioral Health, Substance Abuse, Palliative Care, Asthma and ED Navigator projects.
	R2	The IA recommends the PPS educate their network partners about the available models of transitions of care.	Education to the network partners regarding care transition models of care and care management continues to evolve. Some specific training that have occurred are: All participants in the project specific care transitions workgroup have been trained and provided with Best Practice models such as

			the Bridge Model, Mary Naylor Advanced Practice Model, Project Red and Boost Model. Alliance is partnering with CMS QIO IPRO staff to entrench best practices with our partners. For example, Ellis Hospital has developed readmission risk assessment tool to identify high risk patients for intervention with implementation started in DY2Q3. Best practices will be shared with other network partners in 2017. Providers, behavioral health professionals and project workgroup leads review project status at Clinical Integration and Quality Committee Meetings at least quarterly and report findings to collaborative providers and Care Transitions central workgroup with action items for follow up identified.
2.b.viii Hospital to home			
	R1	The IA recommends the PPS develop a strategy in conjunction with home health agencies to align the documentation in order to prevent miscommunication and missing information.	Alliance has secured Interact Training for our partners. On January 10 and 11th there will be a two day train the trainer training for home health agencies geared for 50 providers. Alliance's objective is that 80% of those trained will in turn train at least one other individual over the ensuing 6 month period. Alliance is holding cross continuum leadership Interact training sessions to increase the number of CBO, Hospital, and Primary Care leadership so that entities are aware and prepared to implement Interact tools consistently across all care settings. This learning session will be held January 2017. Additionally, Alliance is working with our CHHA and health system partners to standardize patient education zones sheets across the care settings to ensure a consistent approach to patient education. Rapid Response Teams are currently being developed with acute care and home health care and other key interdisciplinary providers such as Behavioral Health and Palliative Care,

			utilizing standardized early warning tools and practices. Finally, Alliance is presently working with all partners to implement CrossCHx, a care management platform and messaging system that will allow network providers to communicate and intervene real time. IT rollout to commence early 2017.
	R2	The IA recommends that the PPS workforce committee develop a strategy to recruit home health-aids.	Alliance's workgroup's strategy for recruitment of home health-aids is focusing on redeployment and identifying advancement opportunities for existing staff. Barriers and gaps to successful recruitment have been identified, such as transportation limitations for workers to get to their place of employment. Solutions and alternative initiatives are being discussed, along with determining alternative solutions to recruitment and retention. The PPS workforce committee has developed a strategy to address resource limitation for various health care workers. The Workforce Committee is partnering with Schenectady County Community College to provide opportunities for training and education for community service worker in the health care environment. Additionally the PPS is exploring other innovation solutions to supplement workforce gaps, such as the possibility of telemonitoring, real time data exchanges and connections to health improve patient's access to health care. Progress in these areas with be tracked and reported back to both the Clinical committees and IT committees. IT roll outs to commence in 2017.
3.d.ii Asthma home based			

	R1	The IA recommends the PPS workforce committee develop a strategy to recruit certified asthma educators.	The asthma project workgroup acknowledged the need for additional certified asthma educators (AE-Cs) in March of 2016 and established the following strategy: Alliance and the participating partners will continue to leverage the 2-day Asthma Educator Program offered by St. Peter's Health Partners. This comprehensive program is approved for a total of 14.75 hours of continuing education and is provided by a multidisciplinary team of professionals including: RRT, PharmD, PhD, and MD with no fewer than six of these individuals holding the AE-C credential. Alliance hosted this course twice in 2016 (April 19/20 and Sept. 27/28) with a total of 86 licensed professional from across the region participating. An additional two sessions are scheduled for 2017 (April 4/5 and Sept. 12/13) Alliance contracted with Kettering National Seminars to conduct a 2-day AE-C exam review. Kettering National Seminars is nationally recognized as health care credentialing exam specialist for various professional examinations. This program is approved for a total of 10 hours of continuing education. This course was conducted at Alliance's office on Aug. 18/19 with 28 Alliance partners, (inclusive of CBO and MCO representatives), and an additional 6 seats made available to Albany Medical Center. All those in attendance agreed to sit for the AE-C exam within 90-days of completing the course. Alliance will also offer *THE BUTT STOPS HERE* facilitator certification training program In conjunction with the Promote Tobacco Use Cessation (4.b.i) project. This 7-hour program was hosted at Alliance on Nov. 10, 2016 with a total of 18 individuals from across the PPS in attendance. Alliance is working to solidify the schedule for this training in 2017.

	R2	The IA recommends the PPS develop a standard curriculum to train community health workers in asthma home-based self-management.	Alliance's asthma project workgroup has adopted the *Asthma Education for the Community Health Worker* program from the Association of Asthma Educators as the curriculum to be utilized to train CHWs. This 3-day program is scheduled for early January 2017 and registration is currently underway. We plan to offer this as many times as necessary to satisfy the workforce demands of our collaborating partners inclusive of CBOs. This is the same program that was provided at the NYS Asthma Summit in Albany this past June which was sponsored by the NYS Public Health Association.
	R3	The IA recommends the PPS develop a strategy to engage their patient population in this project.	Alliance actually exceeded the DY2Q2 patient engagement target (104%), and we are tracking favorably and against the DY2Q3 commitment. Capturing patient engagement prior to September 30th was hampered by not having signed partner contracts in place; a situation since rectified. We are continuing to work with our partners and CBOs to develop methods to identify and extract the number of engaged patients from the various EHR systems in place.