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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

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## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Quarterly Report - Implementation Plan for Alliance for Better Health Care, LLC

**Year and Quarter:** DY1, Q3 **Quarterly Report Status:** Adjudicated

**Status By Section**

| Section | Description | Status |
|---|---|---|
| Section 01 | Budget | Completed |
| Section 02 | Governance | Completed |
| Section 03 | Financial Stability | Completed |
| Section 04 | Cultural Competency & Health Literacy | Completed |
| Section 05 | IT Systems and Processes | Completed |
| Section 06 | Performance Reporting | Completed |
| Section 07 | Practitioner Engagement | Completed |
| Section 08 | Population Health Management | Completed |
| Section 09 | Clinical Integration | Completed |
| Section 10 | General Project Reporting | Completed |
| Section 11 | Workforce | Completed |

**Status By Project**

| Project ID | Project Title | Status |
|---|---|---|
| 2.a.i | Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management | Completed |
| 2.b.iii | ED care triage for at-risk populations | Completed |
| 2.b.iv | Care transitions intervention model to reduce 30 day readmissions for chronic health conditions | Completed |
| 2.b.viii | Hospital-Home Care Collaboration Solutions | Completed |
| 2.d.i | Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care | Completed |
| 3.a.i | Integration of primary care and behavioral health services | Completed |
| 3.a.iv | Development of Withdrawal Management (e.g., ambulatory detoxification, ancillary withdrawal services) capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs | Completed |
| 3.d.ii | Expansion of asthma home-based self-management program | Completed |
| 3.g.i | Integration of palliative care into the PCMH Model | Completed |
| 4.a.iii | Strengthen Mental Health and Substance Abuse Infrastructure across Systems | Completed |
| 4.b.i | Promote tobacco use cessation, especially among low SES populations and those with poor mental health. | Completed |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Section 01 – Budget

#### IPQR Module 1.1 - PPS Budget Report (Baseline)

**Instructions :**

This table contains five budget categories. Please add rows to this table as necessary in order to add your own sub-categories. The budget categories used in this table should reflect the budget categories you used in your application. If budget entered varies from PPS application or previous implementation plan submission, please describe changes and justifications in the box provided.

| Budget Items | DY1 ($) | DY2 ($) | DY3 ($) | DY4 ($) | DY5 ($) | Total ($) |
|---|---|---|---|---|---|---|
| **Waiver Revenue** | 37,539,017 | 40,004,254 | 64,691,899 | 57,284,429 | 37,539,017 | 237,058,615 |
| **Cost of Project Implementation & Administration** | **9,384,532** | **10,001,313** | **16,172,947** | **14,321,329** | **9,385,732** | **59,265,853** |
| Implementation | 3,603,660 | 4,720,620 | 10,059,573 | 8,936,509 | 5,856,697 | 33,177,059 |
| PPS Administration | 5,780,872 | 5,280,693 | 6,113,374 | 5,384,820 | 3,529,035 | 26,088,794 |
| **Revenue Loss** | **3,753,813** | **8,001,051** | **16,172,947** | **17,758,448** | **13,515,455** | **59,201,714** |
| **Internal PPS Provider Bonus Payments** | **4,129,194** | **6,000,788** | **20,054,454** | **22,341,273** | **18,621,293** | **71,147,002** |
| **Cost of non-covered services** | **3,753,813** | **4,000,525** | **6,469,179** | **5,728,532** | **3,754,293** | **23,706,342** |
| **Other** | **3,739,248** | **3,985,960** | **6,454,614** | **5,713,967** | **3,739,725** | **23,633,514** |
| Contingency for unforeseen developments over the life of the DSRIP project | 3,739,248 | 3,985,960 | 6,454,614 | 5,713,967 | 3,739,725 | 23,633,514 |
| **Total Expenditures** | **24,760,600** | **31,989,637** | **65,324,141** | **65,863,549** | **49,016,498** | **236,954,425** |
| **Undistributed Revenue** | **12,778,417** | **8,014,617** | **0** | **0** | **0** | **104,190** |

**Current File Uploads**

| User ID | File Type | File Name | File Description | Upload Date |
|---|---|---|---|---|

No Records Found

**Narrative Text :**

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

**Module Review Status**

| Review Status | IA Formal Comments |
|---|---|
| Pass & Complete | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 1.2 - PPS Budget Report (Quarterly)

**Instructions :**

Please include updates on budget items for this quarterly reporting period. Reported actual spending will be compared to baseline projections and deviations will be evaluated.
Any explanations regarding deviations from baseline projections must be included within the textbox, not as narrative within uploaded documentation.

**Benchmarks**

| Waiver Revenue DY1 | Total Waiver Revenue | Undistributed Revenue YTD | Undistributed Revenue Total |
|---|---|---|---|
| 37,539,017 | 237,058,615 | 25,431,644 | 224,951,242 |

| Budget Items | DY1 Q3 Quarterly Amount - Update | Cumulative Spending to Date (DY1 - DY5) | Remaining Balance in Current DY | Percent Remaining in Current DY | Cumulative Remaining Balance | Percent Remaining of Cumulative Balance |
|---|---|---|---|---|---|---|
| **Cost of Project Implementation & Administration** | **3,723,863** | **5,307,728** | **4,076,804** | **43.44%** | **53,958,125** | **91.04%** |
| Implementation | 2,050,355 | | | | | |
| PPS Administration | 1,673,508 | | | | | |
| **Revenue Loss** | **2,241,665** | **2,241,665** | **1,512,148** | **40.28%** | **56,960,049** | **96.21%** |
| **Internal PPS Provider Bonus Payments** | **2,465,782** | **2,465,782** | **1,663,412** | **40.28%** | **68,681,220** | **96.53%** |
| **Cost of non-covered services** | **1,046,099** | **1,046,099** | **2,707,714** | **72.13%** | **22,660,243** | **95.59%** |
| **Other** | **1,046,099** | **1,046,099** | **2,693,149** | **72.02%** | **22,587,415** | **95.57%** |
| Contingency for unforeseen developments over the life of the DSRIP project | 1,046,099 | | | | | |
| **Total Expenditures** | **10,523,508** | **12,107,373** | | | | |

**Current File Uploads**

| User ID | File Type | File Name | File Description | Upload Date |
|---|---|---|---|---|

No Records Found

**Narrative Text :**

For PPS to provide additional context regarding progress and/or updates to IA.

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| |
|---|
| Initial payment to providers totaling $8,850,000 was funded by taking a proportional amount of budgeted funds from each of the Board approved budget line items:<br>Cost of Project Implementation & Administration<br>Revenue Loss<br>Internal PPS Provider Bonus Payments<br>Cost of non-covered services<br>Other |

### Module Review Status

| Review Status | IA Formal Comments |
|---|---|
| Pass & Ongoing | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 1.3 - PPS Flow of Funds (Baseline)

**Instructions :**

In the table below, please detail your PPS's projected flow of DSRIP funds for the next five years, splitting out the flow of funds by provider type. The provider types match the categories used for the Speed & Scale portion of your Project Plan Application.

- This table requires your funds flow projections on an annual basis. Subsequent quarterly reports will require you to submit your actual distribution of funds to these provider categories on a quarterly basis.
- These quarterly submissions of actual funds distribution will ultimately be required at the provider level (as opposed to the provider type level required here)

| Funds Flow Items | DY1 ($) | DY2 ($) | DY3 ($) | DY4 ($) | DY5 ($) | Total ($) |
|---|---|---|---|---|---|---|
| **Waiver Revenue** | 37,539,017 | 40,004,254 | 64,691,899 | 57,284,429 | 37,539,017 | 237,058,615 |
| Practitioner - Primary Care Provider (PCP) | 6,113,343 | 6,514,815 | 10,535,273 | 9,328,944 | 6,113,343 | 38,605,718 |
| Practitioner - Non-Primary Care Provider (PCP) | 2,971,789 | 3,166,950 | 5,121,356 | 4,534,941 | 2,971,789 | 18,766,825 |
| Hospital | 13,264,484 | 14,135,581 | 22,859,008 | 20,241,563 | 13,264,484 | 83,765,120 |
| Clinic | 1,243,621 | 1,325,291 | 2,143,162 | 1,897,762 | 1,243,621 | 7,853,457 |
| Case Management / Health Home | 2,503,538 | 2,667,949 | 4,314,408 | 3,820,392 | 2,503,538 | 15,809,825 |
| Mental Health | 844,486 | 899,944 | 1,455,323 | 1,288,683 | 844,486 | 5,332,922 |
| Substance Abuse | 132,661 | 141,373 | 228,618 | 202,441 | 132,661 | 837,754 |
| Nursing Home | 201,935 | 215,197 | 348,000 | 308,153 | 201,935 | 1,275,220 |
| Pharmacy | 105,891 | 112,845 | 182,484 | 161,589 | 105,891 | 668,700 |
| Hospice | 11,547 | 12,305 | 19,899 | 17,621 | 11,547 | 72,919 |
| Community Based Organizations | 579,882 | 617,964 | 999,325 | 884,898 | 579,882 | 3,661,951 |
| All Other | 3,784,968 | 4,913,347 | 10,371,669 | 9,212,622 | 6,036,805 | 34,319,411 |
| PPS PMO | 5,780,872 | 5,280,693 | 6,113,374 | 5,384,820 | 3,529,035 | 26,088,794 |
| **Total Funds Distributed** | **37,539,017** | **40,004,254** | **64,691,899** | **57,284,429** | **37,539,017** | **237,058,616** |
| **Undistributed Revenue** | **0** | **0** | **0** | **0** | **0** | **0** |

**Current File Uploads**

| User ID | File Type | File Name | File Description | Upload Date |
|---|---|---|---|---|

No Records Found

**Narrative Text :**

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

**Module Review Status**

| Review Status | IA Formal Comments |
|---|---|
| Pass & Complete | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 1.4 - PPS Flow of Funds (Quarterly)

**Instructions :**

Please include updates on flow of funds for this quarterly reporting period. Reported actual fund distribution will be compared to baseline projections and deviations will be evaluated.
Any explanations regarding deviations from baseline projections must be included within the textbox, not as narrative within uploaded documentation.

**Benchmarks**

| Waiver Revenue DY1 | Total Waiver Revenue | Undistributed Revenue YTD | Undistributed Revenue Total |
|---|---|---|---|
| 37,539,017 | 237,058,615 | 25,431,644 | 224,951,242 |

| Funds Flow Items | DY1 Q3 Quarterly Amount - Update | Total Amount Disbursed | Percent Spent By Project | | | | | | | | | | | DY Adjusted Difference | Cumulative Difference |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Projects Selected By PPS | | | | | | | | | | | | |
| | | | 2.a.i | 2.b.iii | 2.b.iv | 2.b.viii | 2.d.i | 3.a.i | 3.a.iv | 3.d.ii | 3.g.i | 4.a.iii | 4.b.i | | |
| Practitioner - Primary Care Provider (PCP) | 1,750,000 | 1,750,000 | 14.41 | 10.98 | 10.95 | 11.18 | 9.11 | 9.32 | 9.4 | 7.55 | 5.71 | 5.3 | 6.09 | 4,363,343 | 36,855,718 |
| Practitioner - Non-Primary Care Provider (PCP) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2,971,789 | 18,766,825 |
| Hospital | 3,600,000 | 3,600,000 | 14.41 | 10.98 | 10.95 | 11.18 | 9.11 | 9.32 | 9.4 | 7.55 | 5.71 | 5.3 | 6.09 | 9,664,484 | 80,165,120 |
| Clinic | 2,600,000 | 2,600,000 | 14.41 | 10.98 | 10.95 | 11.18 | 9.11 | 9.32 | 9.4 | 7.55 | 5.71 | 5.3 | 6.09 | -1,356,379 | 5,253,457 |
| Case Management / Health Home | 450,000 | 450,000 | 14.41 | 10.98 | 10.95 | 11.18 | 9.11 | 9.32 | 9.4 | 7.55 | 5.71 | 5.3 | 6.09 | 2,053,538 | 15,359,825 |
| Mental Health | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 844,486 | 5,332,922 |
| Substance Abuse | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 132,661 | 837,754 |
| Nursing Home | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 201,935 | 1,275,220 |
| Pharmacy | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 105,891 | 668,700 |
| Hospice | 50,000 | 50,000 | 14.41 | 10.98 | 10.95 | 11.18 | 9.11 | 9.32 | 9.4 | 7.55 | 5.71 | 5.3 | 6.09 | -38,453 | 22,919 |
| Community Based Organizations | 50,000 | 50,000 | 14.41 | 10.98 | 10.95 | 11.18 | 9.11 | 9.32 | 9.4 | 7.55 | 5.71 | 5.3 | 6.09 | 529,882 | 3,611,951 |
| All Other | 2,023,508 | 3,607,373 | 9.61 | 9.27 | 9.27 | 9.29 | 9.09 | 9.11 | 9.12 | 8.94 | 8.76 | 8.72 | 8.8 | 177,595 | 30,712,038 |
| PPS PMO | 0 | 0 | | | | | | | | | | | | 5,780,872 | 26,088,794 |
| **Total Funds Distributed** | **10,523,508** | **12,107,373** | | | | | | | | | | | | | |

**Current File Uploads**

| User ID | File Type | File Name | File Description | Upload Date |
|---|---|---|---|---|
| mccarrol | Documentation/Certification | 3_MDL0118_1_3_20160128095854_DY1Q3_OMIG_report.xlsx | DY1Q3 OMIG report | 01/28/2016 09:59 AM |

**Narrative Text :**

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

For PPS to provide additional context regarding progress and/or updates to IA.

Please note that the "All-Other" item above is composed of $350,000 of funds disbursed to providers in the all-other category, and $1,673,508 of funds spent on PPS Administration. These total $2,023,508 (DY1Q3 Quarterly Amount - Update; "All-Other"). Included in the % spent by project is the total "all-Other" amount of $2,023,508.

Data reported on the OMIG DY1Q3 report reflects "actual" distributions to providers or expenses incurred by Alliance as administrative costs. Additional disbursement amounts were approved during this quarter but funds were not distributed before 12/31/2015, reflecting the fact that a number of participation agreements (required to receive those funds) had not yet been fully executed.

### Module Review Status

| Review Status | IA Formal Comments |
|---|---|
| Pass (with Exception) & Ongoing | The amounts and percentages reported in the Provider Import/Export Tool does not align with the amounts and percentages reported in MAPP. Please update all amounts and percentages to ensure alignment and accuracy during the DY1, Q4 reporting period. |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 1.5 - Prescribed Milestones

**Instructions :**

Please provide updates to baseline target dates and work breakdown tasks with target dates for required milestones. For milestones that are due within the reporting period, documentation is required to provide evidence of milestone achievement. Any explanations regarding altered or missed target commitments must be included within the textbox, not as narrative within uploaded documentation.

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| **Milestone #1** Complete funds flow budget and distribution plan and communicate with network | In Progress | Funds Flow Budget and Distribution Plan, signed off by your Finance Committee, including details of your approach to funds flow on a whole-PPS and project-by-project basis; evidence of involvement of provider network in developing funds flow methodology. | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | YES |
| **Task** 1. Staff of AFBHC in conjunction and under the direction of the Finance Committee will develop a funds flow model that will be used by the PPS to distribute DSRIP funds | In Progress | 1. Staff of AFBHC in conjunction and under the direction of the Finance Committee will develop a funds flow model that will be used by the PPS to distribute DSRIP funds | 04/01/2015 | 12/31/2015 | 12/31/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task** 2. Develop budget forms and collection tools to complete data requirements of flow of funds model | Completed | 2. Develop budget forms and collection tools to complete data requirements of flow of funds model | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task** 3. Communicate and engage providers in the flow of funds model to gather input and required data | In Progress | 3. Communicate and engage providers in the flow of funds model to gather input and required data | 04/01/2015 | 12/31/2015 | 12/31/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task** 4. Gather budget data from respective areas of PPS (provider network, projects, central office, etc.) | In Progress | 4. Gather budget data from respective areas of PPS (provider network, projects, central office, etc.) | 04/01/2015 | 12/31/2015 | 12/31/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task** 5. Develop further refined flow of funds and overall budget estimates by DY based upon contract arrangements with providers related to the projects | In Progress | 5. Develop further refined flow of funds and overall budget estimates by DY based upon contract arrangements with providers related to the projects | 04/01/2015 | 12/31/2015 | 12/31/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task** 6. Finance Committee finalizes flow of funds and | In Progress | 6. Finance Committee finalizes flow of funds and presents to | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| presents to AFBHC governing board | | AFBHC governing board | | | | | | | |
| **Task** 7. AFBHC Governing Board approves funds flow budget and distribution plan | In Progress | 7. AFBHC Governing Board approves funds flow budget and distribution plan | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task** 8. Communicate refined funds flow budget and distribution plan to network | In Progress | 8. Communicate refined funds flow budget and distribution plan to network | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |

### IA Instructions / Quarterly Update

| Milestone Name | IA Instructions | Quarterly Update Description |
|---|---|---|

No Records Found

### Prescribed Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|
| Complete funds flow budget and distribution plan and communicate with network | mccarrol | Documentation/Certification | 3_MDL0103_1_3_20160107124435_Template_PPS_Participant_Agreement_for_AFBHC_4843-9718-3015_v_6.doc | Participant Agreement. | 01/07/2016 12:44 PM |

### Prescribed Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|
| Complete funds flow budget and distribution plan and communicate with network | Tasks 1,3,4, and 5, originally scheduled for 12/31/2015 are being moved to 3/31/2016 to reflect the ongoing nature of the development work. Alliance has completed an initial distribution of funds premised on recognition of work on the application and project implementation plan, and signing a basic participation agreement committing to additional participation. That participation agreement is attached. |

### Milestone Review Status

| Milestone # | Review Status | IA Formal Comments |
|---|---|---|
| **Milestone #1** | Pass & Ongoing | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 1.6 - PPS Defined Milestones

**Instructions :**

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones.

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|

No Records Found

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

**IPQR Module 1.7 - IA Monitoring**

**Instructions :**

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

## Section 02 – Governance

### IPQR Module 2.1 - Prescribed Milestones

**Instructions :**

Please enter and update target dates, as well as breakdown tasks with target dates for prescribed milestones. For milestones that are due within the reporting period, documentation is required to provide evidence of milestone achievement.
Any explanations regarding altered or missed target commitments must be included within the textbox, not as narrative within uploaded documentation. Note some milestones include minimum expected completion dates.

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| **Milestone #1**<br>Finalize governance structure and sub-committee structure | Completed | This milestone must be completed by 9/30/2015. Governance and committee structure, signed off by PPS Board. | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | YES |
| **Task**<br>1. Hold first AFBHC, LLC Governance meetings | Completed | a. Hold organizational meeting of Members<br>(1) Ratify Operating Agreement<br>(2) Ratify appointment of Board of Managers<br>b. Hold organizational meeting of Board of Managers<br>(1) Appoint Officers (Chairs, Vice Chair, Secretary)<br>(2) Ratify a Board committee and task force structure | 04/01/2015 | 06/30/2015 | 04/01/2015 | 06/30/2015 | 06/30/2015 | DY1 Q1 | |
| **Task**<br>2. Formally recognize previously-appointed PAC members | Completed | 2. Formally recognize previously-appointed PAC members | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Task**<br>3. Agree on administrative/operating structure including CEO for interim and permanent terms | Completed | "a. Given that the AFBHC and IHANY (Innovative Health Alliance of New York, an ACO created by Ellis and St. Peter's Health Partners that is building a clinically integrated network and operating an MSSP) are now operational, there is concern over duplication of effort. Therefore, an evaluation of the current committee and task force structure will be conducted to develop a recommendation to the respective IHANY and the AFBHC Board of Managers that aligns both entities to the extent permissible under law and DSRIP rules. This evaluation is being done to coordinate patient care standards, to minimize duplication of effort, and to reduce the burden on the practitioner community.<br>b. Present to the AFBHC and IHANY boards the final | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| | | recommendation for and aligned CEO leadership and committee structure solution.<br>" | | | | | | | |
| **Task**<br>4. Install members of the agreed-upon Standing Committees which could include: Finance, Information Technology & Data, Clinical Integration & Quality, Workforce, Credentialing, Audit & Compliance. | Completed | 4. Install members of the agreed-upon Standing Committees which could include: Finance, Information Technology & Data, Clinical Integration & Quality, Workforce, Credentialing, Audit & Compliance. | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Task**<br>5. Schedule monthly meetings of the AFBHC Board of Managers to formally address the issues of the board and issues associated with this milestone demonstrating final accountability for policy and results. | Completed | 5. Schedule monthly meetings of the AFBHC Board of Managers to formally address the issues of the board and issues associated with this milestone demonstrating final accountability for policy and results. | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Milestone #2**<br>Establish a clinical governance structure, including clinical quality committees for each DSRIP project | Completed | This milestone must be completed by 12/31/2015. Clinical Quality Committee charter and committee structure chart | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | YES |
| **Task**<br>1. Write charters for Clinical Integration and Quality Committee and for each subsidiary Project Steering Committee, consider the following in writing charters: | Completed | a. Previously written Adequate Clinical Governance in Project Plan Application, Structure 3<br>b. Process for approving clinical protocols and best practices for all projects in collaboration with the Innovative Health Alliance of New York (IHANY)<br>c. Define accountability for monitoring network's compliance with milestones and metrics | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task**<br>2. Finalize proposed Subsidiary Project Steering committees groupings: Integrated Delivery System & Project 11 (2.a.i and 2.d.i); At Risk Population (2.b.iii, 2.b.iv, 2.b.viii, 3.d.ii, 3.g.i, and 4.b.i); Behavioral Health and Primary Care Integration (3.a.i, 3.a.iv, 4.a.iii) | Completed | 2. Finalize proposed Subsidiary Project Steering committees groupings: Integrated Delivery System & Project 11 (2.a.i and 2.d.i); At Risk Population (2.b.iii, 2.b.iv, 2.b.viii, 3.d.ii, 3.g.i, and 4.b.i); Behavioral Health and Primary Care Integration (3.a.i, 3.a.iv, 4.a.iii) | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task**<br>3. Finalize clinical organizational chart for Clinical Integration and Quality Committee and its subsidiary Project Steering Committees | Completed | 3. Finalize clinical organizational chart for Clinical Integration and Quality Committee and its subsidiary Project Steering Committees | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>4. Install members of the Project Steering Subcommittees, consider current work groups and newly-interested practitioners for membership | Completed | 4. Install members of the Project Steering Subcommittees, consider current work groups and newly-interested practitioners for membership | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task**<br>5. Schedule and hold formal meetings of the Clinical Integration and Quality Committee with minutes | Completed | 5. Schedule and hold formal meetings of the Clinical Integration and Quality Committee with minutes | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task**<br>6. Identify performance metrics to be reviewed by clinical committees, content and frequency of reports to be reviewed, and define committee members' oversight responsibilities. | Completed | 6. Identify performance metrics to be reviewed by clinical committees, content and frequency of reports to be reviewed, and define committee members' oversight responsibilities. | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task**<br>7. Schedule monthly meetings of the Clinical Integration and Quality Committee to formally address the issues associated with this milestone and issues brought up by the three clinical subcommittees. | Completed | 7. Schedule monthly meetings of the Clinical Integration and Quality Committee to formally address the issues associated with this milestone and issues brought up by the three clinical subcommittees. | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Milestone #3**<br>Finalize bylaws and policies or Committee Guidelines where applicable | Completed | This milestone must be completed by 9/30/2015. Upload of bylaws and policies document or committee guidelines. | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | YES |
| **Task**<br>1. Ratify Operating Agreement by Members of the AFBHC. | Completed | 1. Ratify Operating Agreement by Members of the AFBHC. | 04/01/2015 | 06/30/2015 | 04/01/2015 | 06/30/2015 | 06/30/2015 | DY1 Q1 | |
| **Task**<br>2. Create list of necessary AFBHC policies, develop policies and adoption schedule, and present for Board Approval according to schedule. Policies include but are not limited to: Conflict of Interest, Code of Conduct, Corporate Compliance, Whistleblower, Antitrust, Provider Termination for Non-Compliance-, Fund Distribution, HIPAA, Authority to Act, and clinical policies as identified by the Clinical Integration and Quality Committee. This list will continue to | Completed | 2. Create list of necessary AFBHC policies, develop policies and adoption schedule, and present for Board Approval according to schedule. Policies include but are not limited to: Conflict of Interest, Code of Conduct, Corporate Compliance, Whistleblower, Antitrust, Provider Termination for Non-Compliance-, Fund Distribution, HIPAA, Authority to Act, and clinical policies as identified by the Clinical Integration and Quality Committee. This list will continue to evolve. | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| evolve. | | | | | | | | | |
| **Task**<br>3. Ratify the Code of Conduct policy, Corporate Compliance policy, Whistleblower policy, Antitrust policy, and Authority to Act policy | Completed | 3. Ratify the Code of Conduct policy, Corporate Compliance policy, Whistleblower policy, Antitrust policy, and Authority to Act policy | 04/01/2015 | 06/30/2015 | 04/01/2015 | 06/30/2015 | 06/30/2015 | DY1 Q1 | |
| **Task**<br>4. Ratify Conflict of Interest Policy and HIPAA Policy. | Completed | 4. Ratify Conflict of Interest Policy and HIPAA Policy. | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Task**<br>5. Create list of AFBHC committee charters for standing committees and subcommittees, develop, and present to Board of Managers for approval | Completed | 5. Create list of AFBHC committee charters for standing committees and subcommittees, develop, and present to Board of Managers for approval | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Task**<br>6. Create list of AFBHC agreements, develop, and present agreements to Board for approval | Completed | 6. Create list of AFBHC agreements, develop, and present agreements to Board for approval | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Task**<br>7. Develop formal communication channels to inform stakeholders of adopted policies to be implemented as part of daily operating procedures | Completed | 7. Develop formal communication channels to inform stakeholders of adopted policies to be implemented as part of daily operating procedures | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Task**<br>8. Upload board-approved operating agreement, policies, and committee charters onto Medicaid Analytics Performance Portal (MAPP) | Completed | 8. Upload board-approved operating agreement, policies, and committee charters onto Medicaid Analytics Performance Portal (MAPP) | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Milestone #4**<br>Establish governance structure reporting and monitoring processes | Completed | This milestone must be completed by 12/31/2015. Governance and committee structure document, including description of two-way reporting processes and governance monitoring processes | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | YES |
| **Task**<br>1. Write policy on governance and committee structure reporting and monitoring inclusive of two-way communication. Reference Project Plan Application Governance, Structure 2 | Completed | 1. Write policy on governance and committee structure reporting and monitoring inclusive of two-way communication. Reference Project Plan Application Governance, Structure 2 | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Task**<br>2. Define types of reports to be produced including dashboards, reference Performance | Completed | a. Identify key program metrics to evaluate workflow progress in workforce management, financial management, clinical management, and IT management | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| Reporting Section of this Implementation Plan | | | | | | | | | |
| **Task**<br>3. Establish tools and processes for collecting data from providers, incorporating into reports, and deploying meaningful/actionable tools to appropriate parties including Community Based Organizations (CBOs) and social agencies | Completed | 3. Establish tools and processes for collecting data from providers, incorporating into reports, and deploying meaningful/actionable tools to appropriate parties including Community Based Organizations (CBOs) and social agencies | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task**<br>4. Write board recommendation for approval of governance structure, reporting, and monitoring policy | On Hold | 4. Write board recommendation for approval of governance structure, reporting, and monitoring policy | 04/01/2015 | 12/31/2015 | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **Milestone #5**<br>Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement) | Completed | Community engagement plan, including plans for two-way communication with stakeholders. | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | NO |
| **Task**<br>1. Evaluate current composition of community engagement stakeholders and non-provider services to-date to determine their role in effectively implementing AFBHC project plans. Services could include and are not limited to: population health, food, clothing, shelter assistance. Consider additional recruitment of community based organizations providing these services | Completed | a. At a minimum engage those entities listed under the External Stakeholder Section, for example, the State Office of Alcoholism and Substance Abuse Services (https://www.oasas.ny.gov/). This list will evolve as the stakeholder plan is completed. | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task**<br>2. Develop community engagement plan referencing AFBHC Project Plan Application Governance Process 8 (How PPS Governing Body will Engage Stakeholders) including two-way communication | Completed | 2. Develop community engagement plan referencing AFBHC Project Plan Application Governance Process 8 (How PPS Governing Body will Engage Stakeholders) including two-way communication | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task**<br>3. Demonstrate implementation of community engagement plan through community forums, website, newsletter, and social media | Completed | 3. Demonstrate implementation of community engagement plan through community forums, website, newsletter, and social media | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task** | Completed | 4. Define a brand for AFBHC so there is awareness in the | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| 4. Define a brand for AFBHC so there is awareness in the community of the activities of the PPS across the continuum regardless of the patients' entry point inside the continuum | | community of the activities of the PPS across the continuum regardless of the patients' entry point inside the continuum | | | | | | | |
| **Task**<br>5. Schedule community engagement events for current year and subsequent year focusing on public and non-provider organizations | Completed | 5. Schedule community engagement events for current year and subsequent year focusing on public and non-provider organizations | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Milestone #6**<br>Finalize partnership agreements or contracts with CBOs | Completed | Signed CBO partnership agreements or contracts. | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | NO |
| **Task**<br>1. Write partnership agreements with performance addendums with CBOs | Completed | a. Develop list of provider types that need agreements via feedback from project committees<br>b. Identify specific expectations per provider type in reference to project performance<br>c. Obtain provider services agreement from IHANY as a base, adapt to AFBHC, LLC<br>d. Identify general provider expectations to be included in agreement and AFBHC obligations<br>e. Develop provider and CBO incentive principles and payment methodology, which is part of the funds flow policy.<br>f. Obtain Finance Committee, Board of Managers, and Members' approval of funds flow policy" | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task**<br>2. Conduct assessment of needed CBOs and develop contracting strategy | Completed | a. Identify CBOs for contracting, prepare contracts, and schedule negotiations meetings<br>b. Hold meetings with CBOs with minutes, obtain signed agreements | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task**<br>3. Develop process for obtaining signed agreements, storage, retrieval, and renewal | Completed | 3. Develop process for obtaining signed agreements, storage, retrieval, and renewal | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Task**<br>4. Maintain list of active signed provider agreements with filed electronic copies | Completed | 4. Maintain list of active signed provider agreements with filed electronic copies | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task**<br>5. Develop and implement credentialing criteria and processes | On Hold | 5. Develop and implement credentialing criteria and processes | 04/01/2015 | 03/31/2020 | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **Milestone #7** | In Progress | Agency Coordination Plan. | 04/01/2015 | 09/30/2016 | 04/01/2015 | 09/30/2016 | 09/30/2016 | DY2 Q2 | NO |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.) | | | | | | | | | |
| **Task**<br>1. Develop list of state and local public sector agencies to be engaged in projects, reference Project Plan Application Workforce Section 2.6, Collaboration 1 | In Progress | a. Explore and select services from agencies such as the state Office for People with Developmental Disabilities (OPWDD) website that could fulfill AFBHC members' needs identified by projects (http://providerdirectory.opwdd.ny.gov/). Likewise, consider services provided by the services organization listed under the External Stakeholders of this section and in the AFBHC Community Needs Assessment.<br>b. Invite to the planning process the External Stakeholders listed in this section.<br>c. Identify key issues and services needed from public sector agencies.<br>d. Determine the role that each entity may play in the projects and if a contract is necessary to obtain services.<br>e. identify frequency of planning meetings with public sector agencies | 04/01/2015 | 09/30/2016 | 04/01/2015 | 09/30/2016 | 09/30/2016 | DY2 Q2 | |
| **Task**<br>2. Schedule meetings with pertinent public sector agencies and write minutes | In Progress | 2. Schedule meetings with pertinent public sector agencies and write minutes | 04/01/2015 | 09/30/2016 | 04/01/2015 | 09/30/2016 | 09/30/2016 | DY2 Q2 | |
| **Task**<br>3. Develop plan and submit to the appropriate AFBHC Committees and to the Board of Managers for ratification. | In Progress | 3. Develop plan and submit to the appropriate AFBHC Committees and to the Board of Managers for ratification. | 04/01/2015 | 09/30/2016 | 04/01/2015 | 09/30/2016 | 09/30/2016 | DY2 Q2 | |
| **Milestone #8**<br>Finalize workforce communication and engagement plan | In Progress | Workforce communication & engagement plan, including plans for two-way communication with all levels of the workforce, signed off by PPS workforce governance body (e.g. workforce transformation committee). | 04/01/2015 | 06/30/2016 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 | NO |
| **Task**<br>1. Develop Workforce Communication & Engagement Plan referencing material already written in the Workforce Project Plan Application Section 5.7 , Stakeholder & Worker Engagement. Include two-way communication with all levels of | In Progress | 1. Develop Workforce Communication & Engagement Plan referencing material already written in the Workforce Project Plan Application Section 5.7 , Stakeholder & Worker Engagement. Include two-way communication with all levels of workforce | 04/01/2015 | 06/30/2016 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| workforce | | | | | | | | | |
| **Task**<br>2. Identify workforce groups and evaluate general needs for communication | Completed | a. Identify specific communication needs by workforce group and develop messages tailored to each group<br>b. Identify methods and channels of communication best suited for each workforce group and develop distribution plan<br>c. Discuss with employers and labor representatives impact of DSRIP on employees.<br>d. Discuss with employers and labor representatives best methods to engage impacted and non-impacted staff early in the process considering principles of change management. | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task**<br>3. Write formal recommendation to the Workforce Committee for adoption of the Workforce Communication and Engagement Plan with ultimate Board approval. The plan will include target audience, vision, goals, objectives, modes of communication, risks, milestones, and how effectiveness will be measured | In Progress | 3. Write formal recommendation to the Workforce Committee for adoption of the Workforce Communication and Engagement Plan with ultimate Board approval. The plan will include target audience, vision, goals, objectives, modes of communication, risks, milestones, and how effectiveness will be measured | 04/01/2015 | 06/30/2016 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 | |
| **Task**<br>4. Schedule workforce communication events throughout subsequent year | In Progress | 4. Schedule workforce communication events throughout subsequent year | 04/01/2015 | 06/30/2016 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 | |
| **Milestone #9**<br>Inclusion of CBOs in PPS Implementation. | Completed | Explain your plans for contracting with CBOs and their continuing role as your PPS develops over time; detail how many CBOs you will be contracting with and by when; explain how they will be included in project delivery and in the development of your PPS network. | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | NO |
| **Task**<br>1. Building upon relationships developed through the health homes, the PPS intends to contract with approximately 50 CBOs that provide a wide range of services including: housing services for the homeless, food banks, religious service organizations, peer and family mental health advocacy organizations, local public health programs, recovery coaches, and senior support services. | Completed | 1. Building upon relationships developed through the health homes, the PPS intends to contract with approximately 50 CBOs that provide a wide range of services including: housing services for the homeless, food banks, religious service organizations, peer and family mental health advocacy organizations, local public health programs, recovery coaches, and senior support services. | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task** | Completed | 2. Contracting with the bulk of CBOs is expected to be | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| 2. Contracting with the bulk of CBOs is expected to be completed by DY1, Q3. CBOs with major roles in the PPS projects will be the first to be contracted and others will follow as the implementation process dictates. The names of the CBO's are listed under External Stakeholders below and a more comprehensive list is included under Section 3.7 Stakeholder & Community Engagement (Community 3 of the PPS Organizational Application). | | completed by DY1, Q3. CBOs with major roles in the PPS projects will be the first to be contracted and others will follow as the implementation process dictates. The names of the CBO's are listed under External Stakeholders below and a more comprehensive list is included under Section 3.7 Stakeholder & Community Engagement (Community 3 of the PPS Organizational Application). | | | | | | | |
| **Task**<br>3. Representatives from local CBOs have been important participants in the PAC, project development and the PPS Steering Committee. Several selected projects involve community based services and the project teams are chaired by CBO leaders. | Completed | 3. Representatives from local CBOs have been important participants in the PAC, project development and the PPS Steering Committee. Several selected projects involve community based services and the project teams are chaired by CBO leaders. | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |

## IA Instructions / Quarterly Update

| Milestone Name | IA Instructions | Quarterly Update Description |
|---|---|---|
| Finalize governance structure and sub-committee structure | If there have been changes, please describe those changes and upload any supporting documentation as necessary. | Please state if there have been any changes during this reporting quarter. Please state yes or no in the corresponding narrative box. |
| Finalize bylaws and policies or Committee Guidelines where applicable | If there have been changes, please describe those changes and upload any supporting documentation as necessary. | Please state if there have been any changes during this reporting quarter. Please state yes or no in the corresponding narrative box. |

## Prescribed Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|
| Finalize governance structure and sub-committee structure | mccarrol | Documentation/Certification | 3_MDL0203_1_3_20160128140149_DY1Q3_Workforce_Committee_Meeting_Schedule_Template.xlsx | DY1Q3 Workforce Committee Meeting Schedule Template | 01/28/2016 02:01 PM |
| | mccarrol | Documentation/Certification | 3_MDL0203_1_3_20160128135404_Meeting_Schedule-_Finance_Committee.xlsx | DY1Q3 Finance Committee Meeting Schedule | 01/28/2016 01:54 PM |

## NYS Confidentiality – High

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Prescribed Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|
| | mccarrol | Documentation/Certification | 3_MDL0203_1_3_20160128135239_DY1Q3_IT_MeetingSchedule.xlsx | DY1Q3 IT Committee Meeting Schedule Template | 01/28/2016 01:52 PM |
| | mccarrol | Documentation/Certification | 3_MDL0203_1_3_20160128134855_DY1Q3_Audit_and_Compliance_Meeting_Template.xlsx | Audit and Compliance Committee Meeting Template DY1Q3 | 01/28/2016 01:48 PM |
| | mccarrol | Documentation/Certification | 3_MDL0203_1_3_20160128134615_Clinical_Integration_and_Quality_meeting_DOH_template_DY1Q3_(2).xlsx | Clinical Committee Meeting Template | 01/28/2016 01:46 PM |
| | mccarrol | Documentation/Certification | 3_MDL0203_1_3_20160128132725_12182015_Updated_Workforce_and_Finance_Committee_Membership_with_Roles_&_Responsibilities.docx | Updated Rosters for Finance and Workforce Committees | 01/28/2016 01:27 PM |
| | mccarrol | Documentation/Certification | 3_MDL0203_1_3_20160108092023_5.a_Workforce_Committee_Composition.docx | 12/18/2015 Board of Managers item regarding change to Workforce Committee Composition | 01/08/2016 09:20 AM |
| | mccarrol | Documentation/Certification | 3_MDL0203_1_3_20160108091935_3.a_Finance_Committee_Compostion.docx | 12/18/2015 Board of Managers item regarding change to Finance Committee composition | 01/08/2016 09:19 AM |
| Establish a clinical governance structure, including clinical quality committees for each DSRIP project | mccarrol | Documentation/Certification | 3_MDL0203_1_3_20160128140604_Clinical_Integration_and_Quality_meeting_DOH_template_DY1Q3_(2).xlsx | DY1Q3 Clinical Committee Meeting Schedule Template | 01/28/2016 02:06 PM |
| Establish governance structure reporting and monitoring processes | mccarrol | Documentation/Certification | 3_MDL0203_1_3_20160129125323_Gov_M4_Performance_Reporting_and_Communication_Policy.pdf | Performance Reporting policy. | 01/29/2016 12:53 PM |
| Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement) | mccarrol | Documentation/Certification | 3_MDL0203_1_3_20160128142152_Community_Engagement_Template_DY1Q3.xlsx | Community Engagement Template DY1Q3 | 01/28/2016 02:21 PM |
| | mccarrol | Documentation/Certification | 3_MDL0203_1_3_20160128130246_Community_Engagement_Plan_-_Final.docx | Community Engagement Plan | 01/28/2016 01:02 PM |
| Finalize partnership agreements or contracts with CBOs | mccarrol | Documentation/Certification | 3_MDL0203_1_3_20160128142937_CBO_Meeting_Schedule_Template_DY1Q3.xlsx | Community Based Organizations Meeting Schedule Template | 01/28/2016 02:29 PM |
| | mccarrol | Documentation/Certification | 3_MDL0203_1_3_20160128142821_CBOs_Template_DY1Q3.xlsx | Community Based Organizations Template DY1Q3 | 01/28/2016 02:28 PM |
| Inclusion of CBOs in PPS Implementation. | mccarrol | Documentation/Certification | 3_MDL0203_1_3_20160129131605_CBO_Meeting_Schedule_Template_DY1Q3.xlsx | CBO meeting schedule template. | 01/29/2016 01:16 PM |
| | mccarrol | Documentation/Certification | 3_MDL0203_1_3_20160129131304_CBOs_Template_DY1Q3.xlsx | Information on CBOs that Alliance has a relationship with. | 01/29/2016 01:13 PM |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Prescribed Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|
| Finalize governance structure and sub-committee structure | Yes. Please note changes to Workforce and Finance Committee composition pursuant to December 2015 and January 2016 Board of Managers actions as detailed in the attached documents, and updated membership rosters for both Committees. |
| Establish a clinical governance structure, including clinical quality committees for each DSRIP project | Clinical governance structure, including project specific clinical sub-committees have been established. Documentation is available for IA review; Clinical Structure Diagram, Charter, membership, meeting agendas, minutes, sign-in sheets. |
| Finalize bylaws and policies or Committee Guidelines where applicable | No. |
| Establish governance structure reporting and monitoring processes | Governance Structure Reporting and Monitoring Process Policy is written and signed by CEO. Board approval is not required for this Milestone. See also Performance Reporting M1 which must be approved by the Board and submitted as part of DY1Q4 report. |
| Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement) | |
| Finalize partnership agreements or contracts with CBOs | DY1Q3 Alliance Remediation response Gov M6: (1) Alliance has set Governance Milestone # 6 to "In Process." Alliance will work to establish relationships with CBOs identified on the MAPP CBO list that we do not presently have a relationship with. (2) For these CBOs that we establish a relationship with Alliance will seek to execute a participant agreement with them. |
| Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.) | |
| Finalize workforce communication and engagement plan | |
| Inclusion of CBOs in PPS Implementation. | DY1Q3 Alliance Remediation response Gov M9: Alliance recognizes the important role that CBOs have in developing and guiding our principles for the transformation of the health care delivery system in our region. Our strategy calls for including CBOs in all aspects of Alliance planning, oversight, and administration. Accordingly, CBO representatives participate on our project specific work groups and quality sub-committees, as well as on our Clinical Integration and Quality, IT, Audit and Compliance, Finance, and Workforce Committees. Additionally, CBO representatives participate on our Fund Flow Leadership Work Group. Alliance is working to establish relationships with CBOs identified on the MAPP CBO list that we do not presently have a relationship with. For these CBOs that we establish a relationship with Alliance will seek to execute a participant agreement with them. |

### Milestone Review Status

| Milestone # | Review Status | IA Formal Comments |
|---|---|---|
| **Milestone #1** | Pass (with Exception) & Complete | |
| **Milestone #2** | Pass & Complete | |
| **Milestone #3** | Pass & Complete | |
| **Milestone #4** | Pass & Complete | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Milestone Review Status

| Milestone # | Review Status | IA Formal Comments |
|---|---|---|
| **Milestone #5** | Pass & Complete | |
| **Milestone #6** | Pass & Ongoing | The IA has accepted the narrative indicating the intent of the PPS to have this milestone changed to "In process". In DY1Q4 please change your milestone Status to "In process" and update the milestone end date to align with the intent of your narrative submission. |
| **Milestone #7** | Pass & Ongoing | |
| **Milestone #8** | Pass & Ongoing | |
| **Milestone #9** | Pass & Complete | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 2.2 - PPS Defined Milestones

**Instructions :**

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones.

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|

No Records Found

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 2.3 - Major Risks to Implementation & Risk Mitigation Strategies

**Instructions :**

Please describe the key challenges or risks that you foresee in implementing your governance structure and processes and achieving the milestones described above, as well as potential impacts on specific projects and any risks that will undermine your ability to achieve outcome measure targets.

There has been significant progress in aligning IHANY and the Alliance. Some Committees (including Clinical Integration are fully integrated) to ensure coordination of patient care standards. PwC has been retained to further refine Governance and functional integration.

2) Although these is always the potential for conflict and dissension among partners partners, many of whom have been traditional competitors in the marketplace, Alliance has been operating in a constructive, collaborative, and effective manner. Every effort will be made to keep the partnership strong and moving forward in a cohesive fashion.

3) Effective data sharing. The effective sharing of data among the Seven Key Partners and other practitioners is a risk given the different technology platforms being used. The AFBHC Technology Plan will address an orderly approach to sharing data hopefully mitigating this risk.
4) Practitioner engagement and alignment. Engaging 1,400 practitioners to achieve their portion of each project will be a challenge and a risk. Responsibilities by provider types have been identified for each project. Substantial training sessions and communication through several media (planned through Practitioner Engagement Section) are being prepared to promote practitioner engagement and increase the probabilities of successful engagement and alignment with goals. It is also hoped that the targeted incentive program will promote practitioner engagement.

### IPQR Module 2.4 - Major Dependencies on Organizational Workstreams

**Instructions :**

Please describe any interdependencies with other organizational workstreams (IT Systems and Processes, Clinical Integration, etc.)

Major dependencies with Governance center on approval and decision-making processes that result from workstreams. All major decisions of the AFBHC PPS (except those reserved to Members) will come before the Board of Managers. Committee leadership will update the Board monthly to ensure alignment of workstreams. Care management processes and clinical guidelines will go before the Clinical Integration and Quality Committee and subsequent to presentation to the Board of Managers. The Board will be keenly focused on the accomplishment of goals through the project implementation efforts, support provided by IT Systems and Processes, how practitioners remain engaged throughout the implementation and operational phases of projects, ensuring that key health delivery practitioners remain financially viable to serve members, having appropriate levels of trained and engaged workers, and that members are served in a compassionate culturally-competent manner.

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 2.5 - Roles and Responsibilities

**Instructions :**

Please list and elaborate upon the key people/organizations responsible for the development of your governance structure and processes and describe what their responsibilities involve.

| Role | Name of person / organization (if known at this stage) | Key deliverables / responsibilities |
|---|---|---|
| Members (e.g., owners) | Ellis Medicine, Samaritan Hospital of Troy, New York, St. Mary's Healthcare, Whitney M. Young Jr Health Center, Hometown Health Centers. (See individuals' names in key stakeholders section) | Reserved powers, e.g.: amendment of governing documents, disposition of substantially all company's assets, mergers, dissolution, admission of new Member, the adoption or amendment of any methodology for the allocation of DSRIP funds, removal of a manager, appointment of CEO |
| Board of Managers | Seven Key Partners: (Ellis Medicine, Samaritan Hospital of Troy, New York, St. Mary's Healthcare, Whitney M. Young, Jr. Health Center, Inc., Hometown Health Centers, Capital Care Medical Group, P.C., Community Care Physicians, P.C.), two Independent Practitioners, and PAC representative. (See individuals' names in key stakeholders section) | "Oversight of strategic direction, performance and achievement per Implementation Plan. Oversight of PPS Chief Executive Officer, strategic direction, Implementation Plan execution including milestones and metrics, short and long-term financial performance and health of the PPS and key providers, staffing, workforce development and engagement. Development of policies, provider agreements, fund distributions. " |
| Clinical Integration and Quality Committee (AFBHC and IHANY) | Clinical representatives will serve on a fully integrated IHANY/Alliance Clinical Integration and Quality Committee to promote the development of cohesive clinical protocols. | Clinical Integration in AFBHC and IHANY. Adoption of evidence based practices and protocols consistent across all projects and intended to be used uniformly by specific provider types across the network. |
| Finance Committee | CFOs from Board of Managers entities and other community based organizations will serve on the Finance Committee. | Oversee the financial sustainability and health of the AFBHC and practitioners ensuring the short and long term viability of the organization. |
| Health Homes | St. Mary's Healthcare Amsterdam, Samaritan Health Home, Care Central Health Home | Promotion of care coordination and access to social services. Single point of entry for referral to CBOs. |
| Project Advisory Committee | Over 34 members on PAC | Provide the community and overall stakeholder perspective, provide input and guidance over project development. Patients/beneficiaries can participate in ad hoc committees to enhance strategic direction of PPS. |
| Community Based Organizations | Approximately 50 CBOs | Access to social non-provider services. Deliver social services and coordinate with Health Homes and other providers |
| IT Committee | CIOs from Board of Manager entities, RHIO, and other providers | Technology support, making population health and clinical communication possible. Oversee the development and implementation of technology plan to ensure the support for clinical |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Role | Name of person / organization (if known at this stage) | Key deliverables / responsibilities |
|---|---|---|
| | | workflows and timely, safe exchange of patient information. |
| Compliance Officer and Audit and Compliance Committee members | Colleen Susko | Compliance with federal and state laws and other regulations. Ensuring privacy protection and development and oversight of related policies. |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Module 2.6 - IPQR Module 2.6 - Key Stakeholders

**Instructions :**

Please identify the key stakeholders involved, both within and outside the PPS with regard to your governance structure and processes.

| Key stakeholders | Role in relation to this organizational workstream | Key deliverables / responsibilities |
|---|---|---|
| **Internal Stakeholders** | | |
| Ellis Medicine | Paul Milton, Acting CEO,AFBHC, LLC Member and Board of Managers | Founding member, leadership, Board of Managers participant, committee participation. |
| Samaritan Hospital of Troy New York | Jim Reed, M. D., CEO, AFBHC, LLC Member and Board of Managers | Founding member, leadership, Board of Managers participant, committee participation. |
| St. Mary's Healthcare | Victor Giulianelli, CEO, AFBHC Board Chair, LLC Member and Board of Managers | Founding member, leadership, Board of Managers participant, committee participation. |
| Whitney M. Young, Jr. Health Center | David Shippee, CEO, AFBHC, LLC Member and Board of Managers | Founding member, leadership, Board of Managers participant, committee participation. |
| Capital Care Medical Group, P.C. | Lou Snitkoff, M. D., AFBHC, LLC Member and Board of Manager, and Secretary of the Board | Founding member, leadership, Board of Managers participant, committee participation. |
| Community Care Physicians, P.C. | Richard Scanu, COO/CFO, AFBHC, LLC Board of Managers | Leadership, Board of Managers participant, committee participation. |
| Hometown Health Center | Joe Gambino, CEO, AFBHC, LLC Member and Board of Managers, and Vice Chair of the Board | Leadership, Board of Managers participant, committee participation. |
| Independent Practitioners | AFBHC, LLC Board of Managers | Leadership, Board of Managers participant, committee participation. |
| Project Advisory Committee (PAC) representative | Kathy G. Alonge-Coons, LCSWR, Commissioner, Rensselaer County Mental Health, LLC Board of Managers | Leadership, Board of Managers participant, committee participation. |
| **External Stakeholders** | | |
| Schenectady, Albany, Rensselaer, Montgomery, Fulton, Saratoga counties Health Departments | Participation and advice in all projects, and in particular 3.d.ii Asthma project and 4.b.i Tobacco cessation. | Project participation, performance, advice |
| Offices for the Aging (Schenectady, Albany, Rensselaer, Montgomery, Fulton, Saratoga) | Participation and advice in all projects, and in particular 3.g.i Palliative Care | Project participation, performance, advice |
| Rensselaer County Department of Mental Health | Kathy G. Alonge-Coons, LCSWR, Commissioner, serves on the PAC and represents the PAC on the AFBHC Board of Managers. In this role, she brings the perspective of mental health, substance use, and community services to the Board of Managers. In addition Ms. Coons and RCMH staff are instrumental in the development of projects: 3.a.i integration of BH and PC; 3.a.iv | Governance, project participation, performance, advice |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Key stakeholders | Role in relation to this organizational workstream | Key deliverables / responsibilities |
|---|---|---|
| | Development of Withdrawal Mgt. centers, 4.a.iii Strengthen Mental Health and Substance Abuse, 2.d.i patient activation. Assist in development of community engagement plan. | |
| Albany County Department of Mental Health | Stephen J. Giordano, Ph. D., Director, and staff participate in the project implementation plans and are instrumental in the development of projects: 3.a.i integration of BH and PC; 3.a.iv Development of Withdrawal Mgt. centers, 4.a.iii Strengthen Mental Health and Substance Abuse and 4.b.i Promote tobacco use cessation, 2.d.i Patient activation. Assist in the development of the community engagement plan. | Project participation, performance, advice |
| NYS Office of Mental Health | The NYS Dept. of Mental Health was represented during the development of the integration of behavioral health and primary care. The Department guidance will continue to be sought as the project is implemented. Assist in the development of the community engagement plan. | Advice in project development and implementation, overall advice on topic. |
| Schenectady Office of Community Services and Montgomery, Fulton, Saratoga counties Departments of Mental Health. | Participation in the development and implementation of 3.a.i integration of BH and PC; 3.a.iv Development of Withdrawal Mgt. centers, 4.a.iii Strengthen Mental Health and Substance Abuse, 2.d.i Patient Activation. Assist in the development of the community engagement plan. | Project participation, performance, advice |
| State Office of Alcoholism and Substance Abuse Services (OASAS). | Provide guidance I in the development of projects: 3.a.i integration of BH and PC; 3.a.iv Development of Withdrawal Mgt. centers, 4.a.iii Strengthen Mental Health and Substance Abuse, 2.d.i patient activation. Assist in development of community engagement plan. | Project participation, performance, advice |
| State Office for People with Developmental Disabilities (OPWDD) which serves individuals with intellectual disabilities and developmental disabilities (ID/DD). | Participation in the development and implementation of 3.a.i integration of BH and PC; 3a.iv Development of Withdrawal Mgt. centers, 4.a.iii Strengthen Mental Health and Substance Abuse, 2.d.i Patient Activation. Assist in the development of the community engagement plan. | Project participation, performance, advice |
| Unity House of Troy, human services agency including services for the homeless. | Participation in the development and implementation of 3.a.i integration of BH and PC; 3.a.iv Development of Withdrawal Mgt. centers, 4.a.iii Strengthen Mental Health and Substance Abuse, 2.d.i Patient Activation. Assist in the development of the community engagement plan. | Project participation, performance, advice |
| Equinox, Inc.. Provides comprehensive treatment, services, and support in the areas of substance use and mental health, youth shelter, and homeless services. | Provide guidance in the development of projects: 3.a.i integration of BH and PC; 3.a.iv Development of Withdrawal Mgt. centers, 4.a.iii Strengthen Mental Health and Substance Abuse, 2.d.i patient activation. Assist in development of community engagement plan. | Project participation, performance, advice |

# New York State Department Of Health
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## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Key stakeholders | Role in relation to this organizational workstream | Key deliverables / responsibilities |
|---|---|---|
| New York State Division of Criminal Justice System (http://www.criminaljustice.ny.gov/opca/justice-mental-health.htm) | Participation in the development and implementation of 3.a.i integration of BH and PC; 3.a.iv Development of Withdrawal Mgt. centers, 4.a.iii Strengthen Mental Health and Substance Abuse, 2.d.i Patient Activation. Assist in the development of the community engagement plan. | Project participation, performance, advice |
| Bureau of Housing and Support Services (BHSS) (https:otda.ny.gov/programs/housing/) | Provide guidance I in the development of projects: 3.a.i integration of BH and PC; 3.a.iv Development of Withdrawal Mgt. centers, 4.a.iii Strengthen Mental Health and Substance Abuse, 2.d.i patient activation. Assist in development of community engagement plan. | Project participation, performance, advice |
| Health Plans: MVP, Fidelis, CDPHP | Payers for entering into value based payment options and achieving care management goals | Value-based payment contracts. Collaboration in achieving care management protocols |
| Project Advisory Committee (PAC) | Advisory to Board of Managers | Advice on project plan implementation, provide pulse of the community |

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 2.7 - IT Expectations

**Instructions :**

Please clearly describe how the development of shared IT infrastructure across the PPS will support this particular workstream and your ability to achieve the milestones described above.

IT infrastructure is an essential component of creating the appropriate governance structure within and between the PPs within the Albany region. IT infrastructure will be developed to support the following population health management processes: (1) financial and clinical risk stratification; (2) care delivery and coordination; (3) patient engagement; (4) monitoring outcomes; and (5) assessing impact of intervention(s) on overall cost of care. The primary pre-requisite for enabling these processes is acquisition and aggregation of data from across the AFBHC and for the AFBHC attributed population as they receive services outside of the AFBHC. This task is complicated by the many IT systems that are being used across the PPS. In order to better determine the role of HIXNY and other data aggregation platforms, a comprehensive data assessment will be conducted. In parallel to the data assessment, a functionality needs assessment will be conducted at the DSRIP program level to prioritize the IT capabilities needed to support the individual programs. The needs of these individual projects will vary widely, but each will require several IT components to successfully report and sustain the requirements of the individual projects. The data assessment and the functionality needs assessment will drive decision-making about IT infrastructure and IT planning to support population health management program initiatives. The assessment will begin on the capability of using Hixny, the RHIO, to aggregate data about the attributed patients as they receive services inside and outside of the AFBHC. In support of the potential requirement for tracking patients beyond the AFBHC, the PPS will align required IT platforms with the state RHIO to provide event notifications to AFBHC providers for DSRIP patients as they move in and out of care settings throughout this and other State PPS's.

### IPQR Module 2.8 - Progress Reporting

**Instructions :**

Please describe how you will measure the success of this organizational workstream.

The Governance work stream will be successful when all Board and Committee members are fully installed, are well educated about their roles and are able to execute effectively on their oversight responsibility after receiving meaningful written and verbal reports, and the PPS is in control of outcomes. This requires the timely formation of a governance structure with PPS-relevant committees. To be successful in their oversight role, the Board and Committee members must receive timely actionable dashboards and reports so that they can discuss, deliberate and take appropriate action in an effective and efficient manner. To be successful and measure progress, reporting will have to be PPS-wide including the areas of workforce, clinical and projects, finance, administrative, compliance, credentialing, and human resources.

9-24-15 Remediation Response: The PPS will develop a balance score card methodology to track where each project is on a monthly basis. This dashboard will be shared with the Board of Managers (BOM) at their monthly meetings. In addition, each organization will be provided the metrics that they need to achieve for each reporting period and there will be expectations that those metrics are reported to the Alliance on a certain date

each month. Key committees such as the Clinical Integration and Quality Committee (CIQC) will review metrics at their meetings and the PAC will be updated on a quarterly basis when they meet. The intent is for the entire organization to be aware of each party's performance so that the Alliance can begin to evolve into an organization that has codependencies with each other.

### IPQR Module 2.9 - IA Monitoring

**Instructions :**

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

## Section 03 – Financial Stability

### IPQR Module 3.1 - Prescribed Milestones

**Instructions :**

Please enter and update target dates, as well as breakdown tasks with target dates for prescribed milestones. For milestones that are due within the reporting period, documentation is required to provide evidence of milestone achievement.
Any explanations regarding altered or missed target commitments must be included within the textbox, not as narrative within uploaded documentation. Note some milestones include minimum expected completion dates.

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| **Milestone #1**<br>Finalize PPS finance structure, including reporting structure | Completed | This milestone must be completed by 12/31/2015. PPS finance structure chart / document, signed off by PPS Board. | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | YES |
| **Task**<br>1. Finalize Finance Committee Charter. | Completed | 1. Finalize Finance Committee Charter. | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Task**<br>2. Develop financial budgeting and reporting process working with providers, partners and project leads. | Completed | 2. Develop financial budgeting and reporting process working with providers, partners and project leads. | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task**<br>3. Finance Committee briefs AFBHC Governance Board on budgeting and reporting process; process adopted by Board. | Completed | 3. Finance Committee briefs AFBHC Governance Board on budgeting and reporting process; process adopted by Board. | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task**<br>4. Communicate reporting process to provider network | Completed | 4. Communicate reporting process to provider network | 10/01/2015 | 12/31/2015 | 10/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task**<br>5. Begin reporting structure for AFBHC | Completed | 5. Begin reporting structure for AFBHC | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Milestone #2**<br>Perform network financial health current state assessment and develop financial sustainability strategy to address key issues. | In Progress | This milestone must be completed by 3/31/2016. Network financial health current state assessment (to be performed at least annually). The PPS must:<br>- identify those providers in their network that are financially fragile, including those that have qualified as IAAF providers;<br>-- define their approach for monitoring those financially fragile | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | YES |

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

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| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| | | providers, which must include an analysis of provider performance on the following financial indicators: days cash on hand, debt ratio, operating margin and current ratio;<br>-- include any additional financial indicators that they deem necessary for monitoring the financial sustainability of their network providers | | | | | | | |
| **Task**<br>1. Request updated financial reports from all providers of the network with significant attributable lives | Completed | 1. Request updated financial reports from all providers of the network with significant attributable lives | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Task**<br>2. Receive and analyze latest financial reports from major PPS partners and the other providers with significant attributable lives within the PPS that are critical to the projects being implemented. | Completed | 2. Receive and analyze latest financial reports from major PPS partners and the other providers with significant attributable lives within the PPS that are critical to the projects being implemented. | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Task**<br>3. Providers demonstrating fiscal distress, based upon industry benchmarks as selected, will be contacted by AFBHC finance to discuss condition and develop strategies for regaining financial stability | Completed | 3. Providers demonstrating fiscal distress, based upon industry benchmarks as selected, will be contacted by AFBHC finance to discuss condition and develop strategies for regaining financial stability | 06/01/2015 | 12/31/2015 | 06/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task**<br>4. Additional data as needed collected from financially distressed providers including the completion of the DPP where determined needed. | Completed | 4. Additional data as needed collected from financially distressed providers including the completion of the DPP where determined needed. | 06/01/2015 | 12/31/2015 | 06/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task**<br>5. Finalize Distressed Provider Plan (DPP) report and process for monitoring | Completed | 5. Finalize Distressed Provider Plan (DPP) report and process for monitoring | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task**<br>6. Finance Committee presents network financial | In Progress | 6. Finance Committee presents network financial assessment to AFBHC Governing board | 09/30/2015 | 03/31/2016 | 09/30/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |

# New York State Department Of Health
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## DSRIP Implementation Plan Project

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| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| assessment to AFBHC Governing board | | | | | | | | | |
| **Milestone #3** Finalize Compliance Plan consistent with New York State Social Services Law 363-d | Completed | This milestone must be completed by 12/31/2015. Finalized Compliance Plan (for PPS Lead). | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | YES |
| **Task** 1. Develop Audit/Compliance Committee Charter | Completed | 1. Develop Audit/Compliance Committee Charter | 06/01/2015 | 09/30/2015 | 06/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Task** 2. AFBHC Governing Board to appoint Audit/Compliance Committee and Compliance Officer | Completed | 2. AFBHC Governing Board to appoint Audit/Compliance Committee and Compliance Officer | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Task** 3. Develop Compliance Program for AFBHC incorporating the 8 elements required by New York State Social Services Law 363-d, and present to AFBHC Audit/Compliance Board | Completed | 3. Develop Compliance Program for AFBHC incorporating the 8 elements required by New York State Social Services Law 363-d, and present to AFBHC Audit/Compliance Board | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Task** 4. Monitor completion of performance program on a quarterly basis | Completed | 4. Monitor completion of performance program on a quarterly basis | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task** 5. Complete annual Compliance Certification required by OMIG | Completed | 5. Complete annual Compliance Certification required by OMIG | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task** 6. Compliance Officer to provide overview to AFBHC Governing Board on regular basis | Completed | 6. Compliance Officer to provide overview to AFBHC Governing Board on regular basis | 10/01/2015 | 12/31/2015 | 10/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Milestone #4** Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy. | In Progress | This milestone must be completed by 3/31/2016. Value-based payment plan, signed off by PPS board | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | YES |
| **Task** | Completed | 1. AFBHC staff, in collaboration with Finance Committee, | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| 1. AFBHC staff, in collaboration with Finance Committee, gather baseline revenue and methods of reimbursement to determine fee for service and value based payment streams | | gather baseline revenue and methods of reimbursement to determine fee for service and value based payment streams | | | | | | | |
| **Task**<br>2. Review and analyze the VBP arrangements currently in existence within the AFBHC providers to determine if working as intended with providers involved in the VBP arrangements. | Completed | 2. Review and analyze the VBP arrangements currently in existence within the AFBHC providers to determine if working as intended with providers involved in the VBP arrangements. | 07/01/2015 | 12/31/2015 | 07/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task**<br>3. Using analysis of VBP arrangements and provider input, determine if modifications or enhancements are needed to existing arrangements as well as how new arrangements might be developed for the AFBHC. | In Progress | 3. Using analysis of VBP arrangements and provider input, determine if modifications or enhancements are needed to existing arrangements as well as how new arrangements might be developed for the AFBHC. | 08/01/2015 | 12/31/2015 | 12/31/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task**<br>4. AFBHC staff and Finance Committee develop an education and communication strategy for the PPS network including educational materials to be shared with provider network. | Completed | 4. AFBHC staff and Finance Committee develop an education and communication strategy for the PPS network including educational materials to be shared with provider network. | 08/01/2015 | 09/30/2015 | 08/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Task**<br>5. Present educational materials to the provider community to assist providers in understanding VBP systems and gather input on preferred compensation modalities. | In Progress | 5. Present educational materials to the provider community to assist providers in understanding VBP systems and gather input on preferred compensation modalities. | 08/01/2015 | 12/31/2015 | 12/31/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task**<br>6. Providers share input using survey tool on VBP methods, contracting and preferred compensation modalities which is compiled by AFBHC staff. | Completed | 6. Providers share input using survey tool on VBP methods, contracting and preferred compensation modalities which is compiled by AFBHC staff. | 10/01/2015 | 12/31/2015 | 10/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task** | In Progress | 7. AFBHC finalize revenue assessment analysis and VBP | 10/01/2015 | 12/31/2015 | 12/31/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| 7. AFBHC finalize revenue assessment analysis and VBP data and generate report for Finance Committee | | data and generate report for Finance Committee | | | | | | | |
| **Task**<br>8. Finance Committee reviews report and provides comments. | In Progress | 8. Finance Committee reviews report and provides comments. | 01/01/2016 | 03/31/2016 | 01/01/2016 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task**<br>9. Generate final revenue assessment report | In Progress | 9. Generate final revenue assessment report | 01/31/2016 | 03/31/2016 | 01/31/2016 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task**<br>10. Present baseline revenue assessment report to AFBHC governing board for review and approval | In Progress | 10. Present baseline revenue assessment report to AFBHC governing board for review and approval | 02/01/2016 | 03/31/2016 | 02/01/2016 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Milestone #5**<br>Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest | In Progress | This milestone must be completed by 12/31/2016. Value-based payment plan, signed off by PPS board | 04/01/2015 | 12/31/2016 | 04/01/2015 | 12/31/2016 | 12/31/2016 | DY2 Q3 | YES |
| **Task**<br>1. Establish VBP workgroup to develop plan starting with prioritization of potential opportunities and providers for value based arrangements | In Progress | 1. Establish VBP workgroup to develop plan starting with prioritization of potential opportunities and providers for value based arrangements | 09/01/2015 | 06/30/2016 | 09/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 | |
| **Task**<br>2. Engage Medicaid Managed Care Organizations in dialog on value based payment methodologies | In Progress | 2. Engage Medicaid Managed Care Organizations in dialog on value based payment methodologies | 04/01/2015 | 06/30/2016 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 | |
| **Task**<br>3. Identify VBP accelerators and challenges within AFBHC PPS related to implementation of the VBP models including existing ACO and MCO model, shared savings arrangements, IT structure requirements and contracting | In Progress | 3. Identify VBP accelerators and challenges within AFBHC PPS related to implementation of the VBP models including existing ACO and MCO model, shared savings arrangements, IT structure requirements and contracting complexities | 10/01/2015 | 09/30/2016 | 10/01/2015 | 09/30/2016 | 09/30/2016 | DY2 Q2 | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| complexities | | | | | | | | | |
| **Task** 4. Align providers and projects where VBP accelerators and challenges exist to develop timeline for VBP implementation | In Progress | 4. Align providers and projects where VBP accelerators and challenges exist to develop timeline for VBP implementation | 11/01/2015 | 09/30/2016 | 11/01/2015 | 09/30/2016 | 09/30/2016 | DY2 Q2 | |
| **Task** 5. Assess all data and development of VBP timeline with MCOs, AFBHC Finance Committee and staff, and providers workgroup | In Progress | 5. Assess all data and development of VBP timeline with MCOs, AFBHC Finance Committee and staff, and providers workgroup | 01/01/2016 | 09/30/2016 | 01/01/2016 | 09/30/2016 | 09/30/2016 | DY2 Q2 | |
| **Task** 6. Completion of VBP timeline and draft plan by workgroup | In Progress | 6. Completion of VBP timeline and draft plan by workgroup | 04/01/2016 | 12/31/2016 | 04/01/2016 | 12/31/2016 | 12/31/2016 | DY2 Q3 | |
| **Task** 7. Present timeline and plan to Finance Committee for review and comment | In Progress | 7. Present timeline and plan to Finance Committee for review and comment | 06/01/2016 | 12/31/2016 | 06/01/2016 | 12/31/2016 | 12/31/2016 | DY2 Q3 | |
| **Task** 8. Draft plan developed for presentation to boards of AFBHC and MCOs | In Progress | 8. Draft plan developed for presentation to boards of AFBHC and MCOs | 08/01/2016 | 12/31/2016 | 08/01/2016 | 12/31/2016 | 12/31/2016 | DY2 Q3 | |
| **Task** 9. Agreement between AFBHC and MCOs on plan | In Progress | 9. Agreement between AFBHC and MCOs on plan | 11/01/2016 | 12/31/2016 | 11/01/2016 | 12/31/2016 | 12/31/2016 | DY2 Q3 | |
| **Task** 10. Agreement between AFBHC and MCOs on plan approved by respective governing boards | In Progress | 10. Agreement between AFBHC and MCOs on plan approved by respective governing boards | 11/01/2016 | 12/31/2016 | 11/01/2016 | 12/31/2016 | 12/31/2016 | DY2 Q3 | |
| **Milestone #6** Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation | On Hold | | 04/01/2015 | 03/31/2020 | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | YES |
| **Milestone #7** Contract 50% of care-costs through Level 1 | On Hold | | 04/01/2015 | 03/31/2020 | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | YES |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| VBPs, and >= 30% of these costs through Level 2 VBPs or higher | | | | | | | | | |
| **Milestone #8** >=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and >= 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher | On Hold | | 04/01/2015 | 03/31/2020 | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | YES |

### IA Instructions / Quarterly Update

| Milestone Name | IA Instructions | Quarterly Update Description |
|---|---|---|

No Records Found

### Prescribed Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|
| Finalize PPS finance structure, including reporting structure | mccarrol | Documentation/Certification | 3_MDL0303_1_3_20160115120628_Meeting_Schedule-_Finance_Committee.xlsx | Finance Committee Meeting Schedule Template | 01/15/2016 12:06 PM |
| | mccarrol | Documentation/Certification | 3_MDL0303_1_3_20160111151123_7.a.3_AFBHC_Proposed_Governance_Structure.pptx | Governance structure diagram as approved at September Board meeting | 01/11/2016 03:11 PM |
| | mccarrol | Documentation/Certification | 3_MDL0303_1_3_20160111150928_7.a.1_AFBHC_Committee_Structure_Recommendation.docx | September Board item approving Committees including Finance and Audit and Compliance | 01/11/2016 03:09 PM |
| | mccarrol | Documentation/Certification | 3_MDL0303_1_3_20160111150641_Sept_11_2015_Board_of_Managers_Minutes.pdf | September 2015 Board minutes showing Governance items (#8). | 01/11/2016 03:06 PM |
| | mccarrol | Documentation/Certification | 3_MDL0303_1_3_20160111150349_7_b_4_Audit_and_Compliance_Committee_Charter.doc | Audit and Compliance Committee Charter | 01/11/2016 03:03 PM |
| | mccarrol | Documentation/Certification | 3_MDL0303_1_3_20160111133957_3.a_Finance_Committee_Compostion.docx | December Board of Managers item revising Finance Committee composition established at September Board meeting. | 01/11/2016 01:39 PM |
| | mccarrol | Documentation/Certification | 3_MDL0303_1_3_20160111133049_12182015_Updated_Finance_and_Audit_and_Compliance_Committee_Membership_with_Roles_&_Responsibilities.docx | Updated Finance Committee and Audit and Compliance Committee composition pursuant to 12/18/2015 Board of Managers action | 01/11/2016 01:30 PM |
| | mccarrol | Documentation/Certific | 3_MDL0303_1_3_20160108122345_7_b_5_Financ | Finance Committee Charter | 01/08/2016 12:23 PM |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Prescribed Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|
| | | ation | e_Committee_Charter.doc | | |
| Finalize Compliance Plan consistent with New York State Social Services Law 363-d | mccarrol | Documentation/Certification | 3_MDL0303_1_3_20160112113133_OMIG_Compliance_Certification.pdf | Certification confirmation received from NYS OMIG. | 01/12/2016 11:31 AM |

### Prescribed Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|
| Finalize PPS finance structure, including reporting structure | |
| Perform network financial health current state assessment and develop financial sustainability strategy to address key issues. | |
| Finalize Compliance Plan consistent with New York State Social Services Law 363-d | |
| Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy. | Tasks 3, 5, and 7, originally dated 12/31/2015 have been moved to 03/31/2016 to reflect the ongoing nature of the work. |
| Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest | |
| Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation | |
| Contract 50% of care-costs through Level 1 VBPs, and >= 30% of these costs through Level 2 VBPs or higher | |
| >=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and >= 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher | |

### Milestone Review Status

| Milestone # | Review Status | IA Formal Comments |
|---|---|---|
| **Milestone #1** | Pass & Complete | |
| **Milestone #2** | Pass & Ongoing | |
| **Milestone #3** | Pass & Complete | |
| **Milestone #4** | Pass & Ongoing | |
| **Milestone #5** | Pass & Ongoing | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC  (PPS ID:3)

### Milestone Review Status

| Milestone # | Review Status | IA Formal Comments |
|---|---|---|
| **Milestone #6** | Pass & Ongoing | |
| **Milestone #7** | Pass & Ongoing | |
| **Milestone #8** | Pass & Ongoing | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 3.2 - PPS Defined Milestones

**Instructions :**

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones.

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|

No Records Found

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 3.3 - Major Risks to Implementation & Risk Mitigation Strategies

**Instructions :**

Please describe the key challenges or risks that you foresee in implementing these cross-cutting organizational strategies, including potential impacts on specific projects and, crucially, any risks that will undermine your ability to achieve outcome measure targets.

Organizational strategies required for the financial sustainability work stream could impact AFBHC PPS' efforts to achieve the outcome measure targets. Implementation of the financial reporting systems needed to monitor the financial stability of the network is key among these risks. Meaningful progress has been made in developing a common vision of the overall goals of DSRIP and the financial structure in place. Education and communication will continue to insure continuous improvement. A robust IT system supporting collection and analysis of the finances and flow of funds is critical to the success of this work stream. We are currently working with the IT committee in the development of an integrated IT system to not only support the financial work stream, but the full integration of project data and reporting functions. We submitted a capital request under the CRFP offered by DOH, that will be critical in the mitigation of this risk. One of the largest risks is the move from a fee for service payment system to a value based payment system in collaboration with the providers and the MCOs. This collaboration will be difficult as both the PPS and the MCOs have a financial interest in the outcomes, and prior to DSRIP, much of that process has been competitive and not collaborative. In addition, providers currently negotiate payments with MCOs individually, but under DSRIP, it is anticipated that some if not all of the negotiations for VBPs will be done at the PPS level. There will be major hurdles to overcome for this to change and become effective. This change in philosophy will take time and significant communication and support from DOH.

### IPQR Module 3.4 - Major Dependencies on Organizational Workstreams

**Instructions :**

Please describe any interdependencies with other organizational workstreams (IT Systems and Processes, Clinical Integration, etc.)

The financial success of this PPS and the achievement of the goals set forth, will be very dependent on all the other workstreams involved in the PPS. Communication and collaboration among all these workstreams will depend on timely and open communication along with the development of plans that effectively intertwine all the workstreams. The Board of Managers must provide a fully supportive governance process to establish the roles and responsibilities of the AFBHC committees. Information Technology is integral to the success of the projects selected by the PPS. Finance must insure that funds are available for this workstream. The workforce team is currently reviewing an implementation plan related to the impacts, strategies, and costs related to successful transition of the workforce. This will require open and frequent communication with the finance workstream to be successful. Clinical integration is vital for all of the projects and finance must understand how to best support this clinical integration in the most effective and cost efficient way.

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 3.5 - Roles and Responsibilities

**Instructions :**

Please list and elaborate upon the key people/organizations responsible for this organizational workstream and describe what their responsibilities involve.

| Role | Name of person / organization (if known at this stage) | Key deliverables / responsibilities |
|---|---|---|
| Finance Committee Member | Mary Connelly - CFO/Whitney M. Young Health Center | Board level oversight and responsibility for the PPS Finance function; review and approval of finance related policies and procedures; oversight of PPS Lead role, responsibilities and deliverables; oversight of audit and compliance related processes |
| Finance Committee Member | Rusty Senecal - CFO/Capital Care Medical Group | Board level oversight and responsibility for the PPS Finance function; review and approval of finance related policies and procedures; oversight of PPS Lead role, responsibilities and deliverables; oversight of audit and compliance related processes |
| Finance Committee Member | Rick Scanu - CFO/Community Care Physicians | Board level oversight and responsibility for the PPS Finance function; review and approval of finance related policies and procedures; oversight of PPS Lead role, responsibilities and deliverables; oversight of audit and compliance related processes |
| Finance Committee Member | Eric Burton - CFO/Hometown Health Center | Board level oversight and responsibility for the PPS Finance function; review and approval of finance related policies and procedures; oversight of PPS Lead role, responsibilities and deliverables; oversight of audit and compliance related processes |
| Finance Committee Member | Rick Henze - CFO/St Mary's Healthcare | Board level oversight and responsibility for the PPS Finance function; review and approval of finance related policies and procedures; oversight of PPS Lead role, responsibilities and deliverables; oversight of audit and compliance related processes |
| Finance Committee Member | Thomas Schuhle - CFO/St. Peter's Health Partners | Board level oversight and responsibility for the PPS Finance function; review and approval of finance related policies and procedures; oversight of PPS Lead role, responsibilities and deliverables; oversight of audit and compliance related processes |
| Finance Committee Member | Mark Mesick - CFO/Ellis | Board level oversight and responsibility for the PPS Finance |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Role | Name of person / organization (if known at this stage) | Key deliverables / responsibilities |
|---|---|---|
| | | function; review and approval of finance related policies and procedures; oversight of PPS Lead role, responsibilities and deliverables; oversight of audit and compliance related processes |
| Finance Committee Member | In Progress/Clinical Representative | Board level oversight and responsibility for the PPS Finance function; review and approval of finance related policies and procedures; oversight of PPS Lead role, responsibilities and deliverables; oversight of audit and compliance related processes |
| Finance Committee Member | In Progress/Clinical Representative | Board level oversight and responsibility for the PPS Finance function; review and approval of finance related policies and procedures; oversight of PPS Lead role, responsibilities and deliverables; oversight of audit and compliance related processes |
| Finance Committee Member | Millie Ferriter/Community Representative | Board level oversight and responsibility for the PPS Finance function; review and approval of finance related policies and procedures; oversight of PPS Lead role, responsibilities and deliverables; oversight of audit and compliance related processes |
| Finance Committee Member | Sheila Nelson/CDPHP (MCO) | Board level oversight and responsibility for the PPS Finance function; review and approval of finance related policies and procedures; oversight of PPS Lead role, responsibilities and deliverables; oversight of audit and compliance related processes |
| Finance Committee Member | Joseph Twardy/CBO Stakeholder | Board level oversight and responsibility for the PPS Finance function; review and approval of finance related policies and procedures; oversight of PPS Lead role, responsibilities and deliverables; oversight of audit and compliance related processes |
| Finance Committee Member | Paul Milton/Governance Representative | Board level oversight and responsibility for the PPS Finance function; review and approval of finance related policies and procedures; oversight of PPS Lead role, responsibilities and deliverables; oversight of audit and compliance related processes |
| Finance Committee Member | "Anoush Koroghlian-Scott; Julieann Diamond; Robert Swidler /Legal Representative (Rotating Every Six Months)" | Board level oversight and responsibility for the PPS Finance function; review and approval of finance related policies and procedures; oversight of PPS Lead role, responsibilities and deliverables; oversight of audit and compliance related processes |
| Finance Committee Member | Michele Kelly/Community Representative | Board level oversight and responsibility for the PPS Finance function; review and approval of finance related policies and procedures; oversight of PPS Lead role, responsibilities and deliverables; oversight of audit and compliance related processes |
| Chief Financial Officer | Dan Rinaldi (Interim)/AFBHC Finance Office | Provide guidance and oversight for the Funds Flow Plan, the Financial Stability Plan, and other relevant processes. The |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Role | Name of person / organization (if known at this stage) | Key deliverables / responsibilities |
|---|---|---|
| | | responsibilities include managing and distributing funds according to the approved plan, ensuring reporting requirements are met, and that communication regarding the Finance related functions is timely and accurate. |
| Accounting Manager | John Gahan (Interim) /AFBHC Finance Office | Responsible for the daily operations of the Finance Office, including programmatic development of the infrastructure tools critical to the Funds Flow Plan and the related banking, accounts payable and general ledger functions. |
| Accountant/Financial Analyst | Donna Choiniere (Interim)/AFBHC Finance Office | Responsible for assisting Accounting Manager with the day to day activities related to banking, accounts payable and general ledger functions |
| Financial Analyst | In Progress/AFBHC Finance Office | Responsible for assisting Accounting Manager with the day to day activities related to banking, accounts payable and general ledger functions |
| Compliance Officer | Colleen Susko/AFBHC Compliance Officer | Responsible for the development and oversight of AFBHC Compliance Plan and related training, and education; responsible for annual OMIG Compliance Certification |
| Data Analyst | In Progress/AFBHC Finance Office | Responsible for assisting with data analyses, financial sustainability monitoring and reporting required for DSRIP plan implementation |
| Data Analyst | In Progress/AFBHC Finance Office | Responsible for assisting with data analyses, financial sustainability monitoring and reporting required for DSRIP plan implementation |
| VBP Project Manager | In Progress/VBP Committee | Coordinate overall development of VBP baseline assessment and plan for achieving value based payments |
| VP of Performance Operations | Tom McCarroll (Interim)/AFBHC Performance Office | Provide guidance and oversight for the Performance Operations of AFBHC. Works closely with Finance in determing Funds Flow methodology and its relationship to the performance of PPS providers. |
| VP of Clinical Operations | Brenda Maynor (Interim)/AFBHC Clinical Office | Provide guidance and oversight for the Clinical Operations of AFBHC. Works closely with Finance in determing the financial implications of the projects and the budgetary needs for project success. |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 3.6 - Key Stakeholders

**Instructions :**

Please identify the key stakeholders involved, both within and outside the PPS.

| Key stakeholders | Role in relation to this organizational workstream | Key deliverables / responsibilities |
|---|---|---|
| **Internal Stakeholders** | | |
| Joe Twardy/Project Lead | Develop budgets, and provide guidance and support for projects 2.a.i and 2.b.viii workstream | Budgets and reporting for projects; Communication to project management office |
| Scott Friedlander/Project Lead | Develop budgets, provide guidance and support for project 2.b.iii workstream | Budgets and reporting for projects; Communication to project management office |
| Brenda Maynor/Project Lead | Develop budgets, provide guidance and support for project 2.b.iv workstream | Budgets and reporting for projects; Communication to project management office |
| Millie Ferriter/Project Lead | Develop budgets, provide guidance and support for project 3.g.i. workstream | Budgets and reporting for projects; Communication to project management office |
| Dave Shippee/Project Lead | Develop budgets, provide guidance and support for project 3.a.1 and 3.d.ii workstream | Budgets and reporting for projects; Communication to project management office |
| Patrick Carrese/Project Lead | Develop budgets, provide guidance and support for project 3.a.iv workstream | Budgets and reporting for projects; Communication to project management office |
| Keith Brown/Project Lead | Develop budgets, provide guidance and support for project 3.a.iv workstream | Budgets and reporting for projects; Communication to project management office |
| Erin Simao/Project Lead | Develop budgets, provide guidance and support for project 2.d.i workstream | Budgets and reporting for projects; Communication to project management office |
| Pamela Rehak/Project Lead | Develop budgets, provide guidance and support for project 2.a.i workstream | Budgets and reporting for projects; Communication to project management office |
| Katherine Alonge-Coons/Project Lead | Develop budgets, provide guidance and support for project 4.a.iii workstream | Budgets and reporting for projects; Communication to project management office |
| Amanda Mulhern/Project Lead | Develop budgets, provide guidance and support for project 4.b.i workstream | Budgets and reporting for projects; Communication to project management office |
| In Progress/Clinical Integration and Quality Committee Member | Advisement on clinical integration issues related to financial matters | Reports on clinical integration and the effect on financial matters; Communication to clinical staff |
| In Progress/Workforce Committee | Provide input and data related to financial impacts due to workforce modifications | Budgets and reporting for training, redeployment and related workforce issues; Communication to workforce regarding financial matters |
| In Progress/AFBHC IT Manager | Provide appropriate software and system tools for all finance functions | Information Technology related requirements for the finance function; access to data for the finance function reporting |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Key stakeholders | Role in relation to this organizational workstream | Key deliverables / responsibilities |
|---|---|---|
| | | requirements |
| Vic Giulianelli | SMHA CEO and AFBHC Board of Managers | PPS Network Provider partners' BOM have overall responsibility for their organizations' execution of their DSRIP responsibilities, they will contribute to the success of the finance function and finance related strategies |
| William Mayer, MD | SMHA CMO and AFBHC Board of Managers | PPS Network Provider partners' BOM have overall responsibility for their organizations' execution of their DSRIP responsibilities, they will contribute to the success of the finance function and finance related strategies |
| Paul Milton | Ellis CEO and AFBHC Board of Managers | PPS Network Provider partners' BOM have overall responsibility for their organizations' execution of their DSRIP responsibilities, they will contribute to the success of the finance function and finance related strategies |
| Roger Barrowman, MD | Ellis VP/, CEO of Ellis Medical Group, and AFBHC Board of Managers | PPS Network Provider partners' BOM have overall responsibility for their organizations' execution of their DSRIP responsibilities, they will contribute to the success of the finance function and finance related strategies |
| Dave Shippee | Whitney Young CEO and AFBHC Board of Managers | PPS Network Provider partners' BOM have overall responsibility for their organizations' execution of their DSRIP responsibilities, they will contribute to the success of the finance function and finance related strategies |
| Theodore Zeltner, MD | Whitney Young MD and Theodore Zeltner, MD | PPS Network Provider partners' BOM have overall responsibility for their organizations' execution of their DSRIP responsibilities, they will contribute to the success of the finance function and finance related strategies |
| Lou Snitfoff, MD | Capital Care MD and AFBHC Board of Managers | PPS Network Provider partners' BOM have overall responsibility for their organizations' execution of their DSRIP responsibilities, they will contribute to the success of the finance function and finance related strategies |
| Rusty Senecal | Capital Care Director of Finance and AFBHC Board of Managers | PPS Network Provider partners' BOM have overall responsibility for their organizations' execution of their DSRIP responsibilities, they will contribute to the success of the finance function and finance related strategies |
| Rick Scanu | Community Care CFO/COO and AFBHC Board of Managers | PPS Network Provider partners' BOM have overall responsibility for their organizations' execution of their DSRIP responsibilities, they will contribute to the success of the finance function and finance related strategies |
| Barbara A. Morris, MD | Community Care MD and AFBHC Board of Managers | PPS Network Provider partners' BOM have overall responsibility |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Key stakeholders | Role in relation to this organizational workstream | Key deliverables / responsibilities |
|---|---|---|
| | | for their organizations' execution of their DSRIP responsibilities, they will contribute to the success of the finance function and finance related strategies |
| Joe Gambino | Hometown Health CEO and AFBHC Board of Managers | PPS Network Provider partners' BOM have overall responsibility for their organizations' execution of their DSRIP responsibilities, they will contribute to the success of the finance function and finance related strategies |
| David Skory, MD | Hometown Health MD and AFBHC Board of Managers | PPS Network Provider partners' BOM have overall responsibility for their organizations' execution of their DSRIP responsibilities, they will contribute to the success of the finance function and finance related strategies |
| Jim Reed, MD | SPHP CEO and AFBHC Board of Managers | PPS Network Provider partners' BOM have overall responsibility for their organizations' execution of their DSRIP responsibilities, they will contribute to the success of the finance function and finance related strategies |
| Paul Barbarotto, DO | SPHP Physician and AFBHC Board of Managers | PPS Network Provider partners' BOM have overall responsibility for their organizations' execution of their DSRIP responsibilities, they will contribute to the success of the finance function and finance related strategies |
| TBD/AFBHC PMO | Project Management Office | PMO oversight and leadership for oversight of DSRIP initiatives for the PPS |
| TBD | Internal Audit | Oversight of internal controls functions related to funds flow, network provider reporting and other finance related control processes |
| **External Stakeholders** | | |
| Sheila Nelson/CDPHP | Participation in development of value based financial models | Attendance at meetings, providing financial reports and analysis input |
| Timothy Tilton/Fidelis | Participation in development of value based financial models | Attendance at meetings, providing financial reports and analysis input |
| Jordan Estey/MVP | Participation in development of value based financial models | Attendance at meetings, providing financial reports and analysis input |
| Karla Austen/MVP | Participation in development of value based financial models | Attendance at meetings, providing financial reports and analysis input |
| Michele Kazala/MVP | Participation in development of value based financial models | Attendance at meetings, providing financial reports and analysis input |
| PAC Representatives | Input and feed back to assist finance committee | Participation and Communication with PAC committee members |
| Keith Brown /Catholic Charities of the Diocese of | Participate on AFBHC committees | Represent the community through participation in AFBHC DSRIP |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Key stakeholders | Role in relation to this organizational workstream | Key deliverables / responsibilities |
|---|---|---|
| Albany | | committees |
| Aaron Howland/ Catholic Charities of the Diocese of Albany | Participate on AFBHC committees | Represent the community through participation in AFBHC DSRIP committees |
| Robert Schaffer/ PYHIT | Participate on AFBHC committees | Represent the community through participation in AFBHC DSRIP committees |
| Jennifer Sauders/ Liberty ARC | Participate on AFBHC committees | Represent the community through participation in AFBHC DSRIP committees |
| Michael Countryman/ The Family Counseling Center | Participate on AFBHC committees | Represent the community through participation in AFBHC DSRIP committees |
| Greg DeWitt/ Iroquois Healthcare Alliance | Workforce Consultant | Workforce data collection and reporting. Education partnerships. |
| In Progress/External Auditor | External Auditor | Responsible for External Audit function |
| Steve Shepherd / Rensselaer County Department of Mental Health | Government agency and safety net provider | County Agency with oversight and influence on DSRIP related areas |
| DSRIP Support Team/ NYS DOH | Government Agency/Regulator | State Agency and regulatory body with oversight and influence on DSRIP, including waivers of regulations, strategy and support |
| NYS DOH | Government Agency/Regulator | State Agency and regulatory body with oversight and influence on DSRIP, including providing data needed for developing and monitoring success of DSRIP projects, construction/renovation projects and support |
| NYS OMIG | Government Agency/Regulator | State Agency and regulatory body with oversight and influence on DSRIP compliance issues |
| NYS OASAS | Government Agency/Regulator | State Agency and regulatory body with oversight and influence on alcohol and substance abuse DSRIP projects |
| NYS OMH | Government Agency/Regulator | State Agency and regulatory body with oversight and influence on alcohol and substance abuse DSRIP projects |
| HANYS | Healthcare Association | Provide leadership, representation and services to member health care providers |
| Iroquois Healthcare | Healthcare Alliance | Serve as a resource and provide support to members and the communities they serve through advocacy, education, information, cost-saving initiatives and business solutions |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 3.7 - IT Expectations

**Instructions :**

Please clearly describe how the development of shared IT infrastructure across the PPS will support this particular workstream.

The development of a shared IT infrastructure across the PPS is a major pillar that needs to be built and supported in order for the PPS to be successful. This IT integration will allow real time patient data to be shared by the partners in the PPS, such as a patient portal and population health modules that are involved in the various projects undertaken by the PPS. This integration of IT will also allow for the reporting of needed financial and budget information across the PPS in an efficient and expedient manner thus allowing the financial sustainability to be monitored, as well as the flow of DSRIP funding among categories, projects and providers.

### IPQR Module 3.8 - Progress Reporting

**Instructions :**

Please describe how you will measure the success of this organizational workstream.

We will align our AFBHC PPS financial management and sustainability progress reporting with the reporting and oversight structures in place for the DSRIP projects, through the AFBHC PMO. The staff of the AFBHC will be responsible for monitoring progress against project requirements and process measures at a provider level. This information will be shared with the Finance Committee of the AFBHC for review and input, and reports will be generated and shared on a regular basis with the Governing Board of AFBHC to provide input and guidance as well as corrective action if needed. The success of the financial workstream will be measured by the timeliness of the reporting as set forth in the plan, the development and implementation of proactive steps to determine financial sustainability, the avoidance of financial instability of partners, and the communication of this reporting to the partners and community in a timely fashion.

### IPQR Module 3.9 - IA Monitoring

**Instructions :**

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Section 04 – Cultural Competency & Health Literacy

#### IPQR Module 4.1 - Prescribed Milestones

**Instructions :**

Please enter and update target dates, as well as breakdown tasks with target dates for prescribed milestones. For milestones that are due within the reporting period, documentation is required to provide evidence of milestone achievement. Any explanations regarding altered or missed target commitments must be included within the textbox, not as narrative within uploaded documentation. Note some milestones include minimum expected completion dates.

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| **Milestone #1**<br>Finalize cultural competency / health literacy strategy. | Completed | This milestone must be completed by 12/31/2015. Cultural competency / health literacy strategy signed off by PPS Board. The strategy should:<br>-- Identify priority groups experiencing health disparities (based on your CNA and other analyses);<br>-- Identify key factors to improve access to quality primary, behavioral health, and preventive health care<br>-- Define plans for two-way communication with the population and community groups through specific community forums<br>-- Identify assessments and tools to assist patients with self-management of conditions (considering cultural, linguistic and literacy factors); and<br>-- Identify community-based interventions to reduce health disparities and improve outcomes. | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | YES |
| **Task**<br>1. Establish a Task Force with representation from PPS partners and community based organizations to review and refine AFBHC's Cultural Competence / Health Literacy / Community Engagement strategy. | Completed | 1. Establish a Task Force with representation from PPS partners and community based organizations to review and refine AFBHC's Cultural Competence / Health Literacy / Community Engagement strategy. | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Task**<br>2. Refine PPS strategy defined in the Cultural Competency/Health Literacy DSRIP application. Plan will include the following: | Completed | 2. Refine PPS strategy defined in the Cultural Competency/Health Literacy DSRIP application. Plan will include the following: | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task** | Completed | 3. Develop schedule and support the Seven Key Partners | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |

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## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| 3. Develop schedule and support the Seven Key Partners (Ellis Hospital, Samaritan Hospital of Troy, New York, St. Mary's Healthcare, Whitney M. Young, Jr. Health Center, Inc., Hometown Health Centers, Capital Care Medical Group, P.C., Community Care Physicians, P.C.) to conduct a Cultural Competency, Health Literacy, Engagement Self-Assessment to establish baseline current state. Based on results, refine tactical plan to accomplish strategy. (Using/adapting assessment tools from NWICA Cultural Competency Organizational Questionnaire, Emory University Health Plan Organizational Assessment of Health Literacy Activities, and the Carmen, et. al. "Multidimensional Framework for Patient and Family Engagement in Health and Health Care.") | | (Ellis Hospital, Samaritan Hospital of Troy, New York, St. Mary's Healthcare, Whitney M. Young, Jr. Health Center, Inc., Hometown Health Centers, Capital Care Medical Group, P.C., Community Care Physicians, P.C.) to conduct a Cultural Competency, Health Literacy, Engagement Self-Assessment to establish baseline current state. Based on results, refine tactical plan to accomplish strategy. (Using/adapting assessment tools from NWICA Cultural Competency Organizational Questionnaire, Emory University Health Plan Organizational Assessment of Health Literacy Activities, and the Carmen, et. al. "Multidimensional Framework for Patient and Family Engagement in Health and Health Care.") | | | | | | | |
| **Task** "4. Develop Health Literacy Guideline: Standardize literacy screening by adding the SILS (Single Item Literacy Screener) to admission / intake processes and documentation; define interventions per literacy level; standardize / align patient materials and caregiver tools; begin to track outcomes by literacy " | Completed | "4. Develop Health Literacy Guideline: Standardize literacy screening by adding the SILS (Single Item Literacy Screener) to admission / intake processes and documentation; define interventions per literacy level; standardize / align patient materials and caregiver tools; begin to track outcomes by literacy " | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task** "5. Develop Cultural Competency Guideline: Refine demographic characteristics assessed on admission / intake to more accurately capture cultural needs; define interventions according to population's needs; standardize / align patient materials and caregiver tool; begin to track outcomes for disparate population groups " | Completed | "5. Develop Cultural Competency Guideline: Refine demographic characteristics assessed on admission / intake to more accurately capture cultural needs; define interventions according to population's needs; standardize / align patient materials and caregiver tool; begin to track outcomes for disparate population groups " | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task** | Completed | "6. Establish standards and expectations for community | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| "6. Establish standards and expectations for community advisory roles; implement advisory processes at governance level, program, unit , and practice levels as indicated | | advisory roles; implement advisory processes at governance level, program, unit , and practice levels as indicated | | | | | | | |
| **Task** 7. Review suggested structure, process, and outcome evaluation measures and develop cultural comp/health lit/ engagement dashboard. Include health outcomes for defined disparate groups. | Completed | 7. Review suggested structure, process, and outcome evaluation measures and develop cultural comp/health lit/ engagement dashboard. Include health outcomes for defined disparate groups. | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task** 8. Explore adding cultural competency & health literacy item set to HCAHPS survey | Completed | 8. Explore adding cultural competency & health literacy item set to HCAHPS survey | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task** 9. Cultural Competency and Health Literacy Task force reviews strategy | Completed | 9. Cultural Competency and Health Literacy Task force reviews strategy | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task** 10. Submit the cultural competency / health literacy strategy to PPS board for approval. | Completed | 10. Submit the cultural competency / health literacy strategy to PPS board for approval. | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Milestone #2** Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material). | In Progress | This milestone must be completed by 6/30/2016. Cultural competency training strategy, signed off by PPS Board. The strategy should include:<br>-- Training plans for clinicians, focused on available evidence-based research addressing health disparities for particular groups identified in your cultural competency strategy<br>-- Training plans for other segments of your workforce (and others as appropriate) regarding specific population needs and effective patient engagement approaches | 04/01/2015 | 06/30/2016 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 | YES |
| **Task** 1. Determine baseline cultural competency training needs of staff, including those working with special populations (Behavioral Health, ID/IDD, substance use), through evidence-based cultural competency assessments and advisement from state agencies and CBOs. | In Progress | 1. Determine baseline cultural competency training needs of staff, including those working with special populations (Behavioral Health, ID/IDD, substance use), through evidence-based cultural competency assessments and advisement from state agencies and CBOs. | 04/01/2015 | 12/31/2015 | 12/31/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task** 2. Identify best practices throughout the PPS for | In Progress | 2. Identify best practices throughout the PPS for training staff about cultural and linguistic sensitive behavior for working | 04/01/2015 | 12/31/2015 | 12/31/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| training staff about cultural and linguistic sensitive behavior for working with ethnic minorities, persons in poverty, LGBTQ, disabilities, substance abuse. Evaluate best practices for deployment across the PPS. | | with ethnic minorities, persons in poverty, LGBTQ, disabilities, substance abuse. Evaluate best practices for deployment across the PPS. | | | | | | | |
| **Task**<br>3. Staff: Using the Standards for Culturally and Linguistically Appropriate Services (CLAS) as a guide, coordinate with the Workforce Workstream to design training goals, curriculum, target audience, methods, system for tracking completion, training schedule, and evaluation plan to prepare staff to be culturally and linguistically competent. | In Progress | 3. Staff: Using the Standards for Culturally and Linguistically Appropriate Services (CLAS) as a guide, coordinate with the Workforce Workstream to design training goals, curriculum, target audience, methods, system for tracking completion, training schedule, and evaluation plan to prepare staff to be culturally and linguistically competent. | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task**<br>"4. Patients: Research strategies such as a Self-Management Education Program (ex. Standard Self-Management Model) that are administered from the PPS level to increase capacity and flexibility of offerings. Research models that have been adapted to different cultures and may be taught in multiple languages. (Stanford Chronic Disease Self Management model or similar program)<br>" | In Progress | "4. Patients: Research strategies such as a Self-Management Education Program (ex. Standard Self-Management Model) that are administered from the PPS level to increase capacity and flexibility of offerings. Research models that have been adapted to different cultures and may be taught in multiple languages. (Stanford Chronic Disease Self Management model or similar program)<br>" | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task**<br>5. Conduct assessment of identified CBOs to determine capacity to assist with training, outreach and engagement activities to the target populations and develop contracting strategy. | In Progress | 5. Conduct assessment of identified CBOs to determine capacity to assist with training, outreach and engagement activities to the target populations and develop contracting strategy. | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task**<br>6. Community Health Workers (CHW): Using NY benchmarks as guide, establish expectations, standards, and onboarding curriculum to prepare Community Health Workers for positions in their own communities. Explore and adapt innovative outreach strategies to engage diverse | In Progress | 6. Community Health Workers (CHW): Using NY benchmarks as guide, establish expectations, standards, and onboarding curriculum to prepare Community Health Workers for positions in their own communities. Explore and adapt innovative outreach strategies to engage diverse populations (e.g. promotoras for the Hispanic/Latino community). | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |

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## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| populations (e.g. promotoras for the Hispanic/Latino community). | | | | | | | | | |
| **Task** 7. Patient, Family, Community Engagement. Using the AHRQ Working With Patient and Families as Advisors Implementation Handbook as a guide, develop a training program for advisor roles in the PPS. | In Progress | 7. Patient, Family, Community Engagement. Using the AHRQ Working With Patient and Families as Advisors Implementation Handbook as a guide, develop a training program for advisor roles in the PPS. | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task** 8. Cultural Competency and Health Literacy Task force reviews training plan. | In Progress | 8. Cultural Competency and Health Literacy Task force reviews training plan. | 04/01/2015 | 06/30/2016 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 | |
| **Task** 9. Submit plan to AFBHC Board for approval. | In Progress | 9. Submit plan to AFBHC Board for approval. | 04/01/2015 | 06/30/2016 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 | |
| **Task** 10. Determine roll-out logistics and implement strategy. | In Progress | 10. Determine roll-out logistics and implement strategy. | 04/01/2015 | 06/30/2016 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 | |

## IA Instructions / Quarterly Update

| Milestone Name | IA Instructions | Quarterly Update Description |
|---|---|---|

No Records Found

## Prescribed Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|
| Finalize cultural competency / health literacy strategy. | mccarrol | Documentation/Certification | 3_MDL0403_1_3_20160315142624_DY1Q3_remediation_CC_HL_#_1_board_chair_letter_signed.pdf | Confirming letter from Alliance Board Chair | 03/15/2016 02:26 PM |
| | mccarrol | Documentation/Certification | 3_MDL0403_1_3_20160128125335_Meeting_Schedule_Template_DY1Q3_Community_Engagement.xlsx | DY1Q3 Meeting Schedule Template Community Engagment | 01/28/2016 12:53 PM |
| | mccarrol | Documentation/Certification | 3_MDL0403_1_3_20160128125240_Cultural_Competency_and_Health_Literacy_Strategy-_Final_for_Submission.docx | CC / HL Strategy | 01/28/2016 12:52 PM |
| | mccarrol | Documentation/Certification | 3_MDL0403_1_3_20160118101226_EC_12292015_item_Cultural_Competency_Stragtegy_Approval. | Item approving CC/HL strategy | 01/18/2016 10:12 AM |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Prescribed Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|
| | | | docx | | |
| | mccarrol | Documentation/Certification | 3_MDL0403_1_3_20160118101134_Board_item_assignment_to_EC_of_Cultural_Competency_Stragtegy_Approval.docx | Assignment of authority to approve to Executive Committee of Board | 01/18/2016 10:11 AM |

### Prescribed Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|
| Finalize cultural competency / health literacy strategy. | DY1Q3 Alliance remediation response: Alliance uploaded additional documentation into MAPP in support of Cultural Competency milestone 1 establishing board approval of the CC / HL strategy. |
| Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material). | Tasks 1, and 2, originally scheduled for 12/31/2015 completion have been moved to 3/31/2016 to reflect the ongoing nature of the work. |

### Milestone Review Status

| Milestone # | Review Status | IA Formal Comments |
|---|---|---|
| **Milestone #1** | Pass & Complete | |
| **Milestone #2** | Pass & Ongoing | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 4.2 - PPS Defined Milestones

**Instructions :**

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones.

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|

No Records Found

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 4.3 - Major Risks to Implementation & Risk Mitigation Strategies

**Instructions :**

Please describe the key challenges or risks that you foresee in implementing your cultural competency / health literacy strategy and addressing the specific health disparities you are targeting (based on your CNA), and achieving the milestones described above - including potential impacts on specific projects and any risks that will undermine your ability to achieve outcome measure targets.

One risk in implementing the Cultural Competency / Health Literacy Strategy and training is that historically, programs for reducing health disparities and improving outcomes for underserved and marginalized populations have depended on time-limited grant and program funding. As a mitigation strategy, the PPS will identify sustainable funding for key programs addressing health disparities. Because cultural competence is tied to one's own individual value system, lack of workforce and provider engagement in behavior change is a risk for successfully implementing the cultural competency/health literacy/engagement strategy. To mitigate this risk, the CCO will partner with the Schenectady Bridges Out of Poverty Program to train frontline workers, community service providers and healthcare providers to understand the barriers experienced by people living in poverty. The CCO will use a training-the-trainer philosophy and approach to promote peer to peer learning and extend the network of expertise throughout the PPS. Patient education materials will be aligned and standardized to ensure that frontline workers and providers have easy access to the tools they need. To embed cultural competency, health literacy and patient engagement into daily patient / client interfaces, guidelines are being developed that will be triggered by an intake / admission assessment, similar to risks for medical conditions like assessing risk for deep vein thrombosis (DVT) on hospital admission.

### IPQR Module 4.4 - Major Dependencies on Organizational Workstreams

**Instructions :**

Please describe any interdependencies with other organizational workstreams (IT Systems and Processes, Clinical Integration, etc.)

Cultural competency must be integrated into the PPS's overall strategic planning. In selecting projects, the PPS considered those marginalized populations identified in the CNA: persons with or at risk for mental, emotional and behavior health disorders; persons with substance abuse disorders; persons living in poverty or low-income; persons without access to primary care; and ethnic minorities. Individuals in one or more of these populations often have multiple chronic illnesses and are high health care utilizers. The Cultural Competency Office (CCO) will continue program development and evaluation of projects to support these subpopulations. Planning and executing the training strategy will be coordinated with the Workforce workstream to leverage existing training resources and infrastructure and to track training participation and completion. The cultural competency strategy is a cross-cutting intervention that applies to all DSRIP projects and will be embedded into each project planning and implementation plan through policies and procedures, workflow design, and workforce selection.

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 4.5 - Roles and Responsibilities

**Instructions :**

Please list and elaborate upon the key people/organizations responsible for this workstream and describe what their responsibilities involve.

| Role | Name of person / organization (if known at this stage) | Key deliverables / responsibilities |
|---|---|---|
| PPS cultural competency / health literacy / community engagement lead / Project 11 (2.d.i) lead | Erin Simao | Develop, coordinate, oversee and align PPS cultural competency, health literacy and community engagement strategy and training |
| Cultural Competency and Health Literacy Task force | In Progress | Develop, coordinate, oversee and align PPS cultural competency, health literacy and community engagement strategy and training |
| Project lead for 2.b.iii, 2.b.iv, 3.g.i | Scott Friedlander | Integrate cultural competency and health literacy protocols in the implementation of the projects |
| Project Leads for 2.a.i, 2.b.viii, 3.a.i, 3.a.iv, 3.d.ii, 4.a.iii, 4.b.i | In Progress | Integrate cultural competency and health literacy protocols in the implementation of the projects |
| Community based organizations | Approximately 50 CBOs to be engaged | "Collaborate for CHW recruitment, training and placement Participate in community advisory committees, inform training curriculum and conduct components of the training " |
| Workforce Committee | In Progress | "Collaborate for CHW recruitment, training and placement Collaborate for organizing, delivering and tracking training and participation" |
| IT & Data Committee | CIOs from Board of Manager entities, RHIO, and other providers | Technology support, making population health and clinical communication possible. Oversee the development and implementation of technology plan to ensure the support for clinical workflows and timely and safe exchange of patient information. |
| Participation and advice in all projects, and in particular 3.d.ii Asthma project and 4.b.i Tobacco cessation. | Schenectady, Albany, Rensselaer, Montgomery, Fulton, Saratoga counties Health Departments | Project participation, performance, advice |
| Participation and advice in all projects, and in particular 3.g.i Palliative Care | Offices for the Aging (Schenectady, Albany, Rensselaer, Montgomery, Fulton, Saratoga) | Project participation, performance, advice |
| Ms. Kathy G. Alonge-Coons, LCSWR, Commissioner, serves on the PAC and represents the PAC on the AFBHC Board of Managers. In this role, she brings the perspective of mental health, substance use, and community services to the Board of Managers. In addition Ms. Coons and RCMH staff are instrumental in the development of projects: 3.a.i integration of BH | Rensselaer County Department of Mental Health | Governance, project participation, performance, advice |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Role | Name of person / organization (if known at this stage) | Key deliverables / responsibilities |
|---|---|---|
| and PC; 3.a.iv Development of Withdrawal Mgt. centers, 4.a.iii Strengthen Mental Health and Substance Abuse, 2.d.i patient activation. Assist in development of community engagement plan. | | |
| Stephen J. Giordano, Ph. D., Director, and staff participate in the project implementation plans and are instrumental in the development of projects: 3.a.i integration of BH and PC; 3.a.iv Development of Withdrawal Mgt. centers, 4.a.iii Strengthen Mental Health and Substance Abuse and 4.b.i Promote tobacco use cessation, 2.d.i Patient activation. Assist in the development of the community engagement plan. | Albany County Department of Mental Health | Project participation, performance, advice |
| The NYS Dept. of Mental Health was represented during the development of the integration of behavioral health and primary care. The Department guidance will continue to be sought as the project is implemented. Assist in the development of the community engagement plan. | NYS Office of Mental Health | Advice in project development and implementation, overall advice on topic. |
| Participation in the development and implementation of 3.a.i integration of BH and PC; 3.a.iv Development of Withdrawal Mgt. centers, 4.a.iii Strengthen Mental Health and Substance Abuse, 2.d.i Patient Activation. Assist in the development of the community engagement plan. | Schenectady Office of Community Services and Montgomery, Fulton, Saratoga counties Departments of Mental Health. | Project participation, performance, advice |
| Provide guidance I in the development of projects: 3.a.i integration of BH and PC; 3.a.iv Development of Withdrawal Mgt. centers, 4.a.iii Strengthen Mental Health and Substance Abuse, 2.d.i patient activation. Assist in development of community engagement plan. | State Office of Alcoholism and Substance Abuse Services (OASAS). | Project participation, performance, advice |
| Participation in the development and implementation of 3.a.i integration of BH and PC; 3a.iv Development of Withdrawal Mgt. centers, 4.a.iii Strengthen Mental Health and Substance Abuse, 2.d.i Patient Activation. Assist in the development of the community engagement plan. | State Office for People with Developmental Disabilities (OPWDD) which serves individuals with intellectual disabilities and developmental disabilities (ID/DD). | Project participation, performance, advice |
| Participation in the development and implementation of 3.a.i integration of BH and PC; | Unity House of Troy, human services agency including services for the homeless. | Project participation, performance, advice |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Role | Name of person / organization (if known at this stage) | Key deliverables / responsibilities |
|---|---|---|
| 3.a.iv Development of Withdrawal Mgt. centers, 4.a.iii Strengthen Mental Health and Substance Abuse, 2.d.i Patient Activation. Assist in the development of the community engagement plan. | | |
| Provide guidance I in the development of projects: 3.a.i integration of BH and PC; 3.a.iv Development of Withdrawal Mgt. centers, 4.a.iii Strengthen Mental Health and Substance Abuse, 2.d.i patient activation. Assist in development of community engagement plan. | Equinox, Inc.. Provides comprehensive treatment, services, and support in the areas of substance use and mental health, youth shelter, and homeless services. | Project participation, performance, advice |
| Participation in the development and implementation of 3.a.i integration of BH and PC; 3.a.iv Development of Withdrawal Mgt. centers, 4.a.iii Strengthen Mental Health and Substance Abuse, 2.d.i Patient Activation. Assist in the development of the community engagement plan. | New York State Division of Criminal Justice System (http://www.criminaljustice.ny.gov/opca/justice-mental-health.htm) | Project participation, performance, advice |
| Provide guidance I in the development of projects: 3.a.i integration of BH and PC; 3.a.iv Development of Withdrawal Mgt. centers, 4.a.iii Strengthen Mental Health and Substance Abuse, 2.d.i patient activation. Assist in development of community engagement plan. | Bureau of Housing and Support Services (BHSS) (https:otda.ny.gov/programs/housing/) | Project participation, performance, advice |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 4.6 - Key Stakeholders

**Instructions :**

Please identify the key stakeholders involved, both within and outside the PPS.

| Key stakeholders | Role in relation to this organizational workstream | Key deliverables / responsibilities |
|---|---|---|
| **Internal Stakeholders** | | |
| Board of Managers | Leadership | "Approve organizational structure with Cultural Competency / Health Literacy / Engagement office and staff<br>Approve Cultural Competency / Health Literacy / Engagement strategy" |
| Ellis Medicine | AFBHC partner | Conduct current state assessment; support staff and providers to attend training; demonstrate cultural competency/health literacy/engagement views in administrative policies, procedures and practices |
| St. Peters Health Partners | Active Parent of AFBHC partner | Conduct current state assessment; support staff and providers to attend training; demonstrate cultural competency/health literacy/engagement views in administrative policies, procedures and practices |
| Whitney M. Young, Jr. Health Center | AFBHC partner | Conduct current state assessment; support staff and providers to attend training; demonstrate cultural competency/health literacy/engagement views in administrative policies, procedures and practices |
| Hometown Health Centers | AFBHC partner | Conduct current state assessment; support staff and providers to attend training; demonstrate cultural competency/health literacy/engagement views in administrative policies, procedures and practices |
| St. Mary's Healthcare | AFBHC partner | Conduct current state assessment; support staff and providers to attend training; demonstrate cultural competency/health literacy/engagement views in administrative policies, procedures and practices |
| Community Care Physicians, P.C. | AFBHC partner | Conduct current state assessment; support staff and providers to attend training; demonstrate cultural competency/health literacy/engagement views in administrative policies, procedures and practices |
| Capital Care Medical Group, P.C. | AFBHC partner | Conduct current state assessment; support staff and providers to attend training; demonstrate cultural competency/health literacy/engagement views in administrative policies, procedures |

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| Key stakeholders | Role in relation to this organizational workstream | Key deliverables / responsibilities |
|---|---|---|
| | | and practices |
| Innovative Health Alliance of New York, LLC (IHANY) | Innovative Health Alliance of New York LLC (IHANY) is an Accountable Care Organization (ACO) participating in the Medicare Shared Savings Program (MSSP). IHANY has the same service area and many of the same partners and providers as AFBHC, so the two entities expect to share appropriate functions to maximize efficiency and effectiveness. | Include cultural competency / health literacy / patient engagement perspectives in clinical guidelines (i.e. ethnic groups at risk for certain diseases) |
| PPS members and affiliates | Carry out cultural competency / health literacy / community engagement strategy | "Deliver culturally and language appropriate services to improve health outcomes<br>" |
| **External Stakeholders** | | |
| PAC | Advisor | Provide input and feedback from community |
| SHIP and PHIPS Programs | Subject matter and training expertise | Collaborate on training development and delivery |
| Bridges Out of Poverty | Subject matter expertise | Collaborate on training development and delivery |
| US Committee for Refugees and Immigrants | Subject matter expertise | English as a Second Language training |
| Healthy Capital District Initiative | Subject matter expertise | Collaborate on training development and delivery |
| "Schenectady Community College<br>SUNY" | Contribute experience from the HPOG demonstration project | Post-secondary program collaboration |

## IPQR Module 4.7 - IT Expectations

**Instructions :**

Please clearly describe how the development of shared IT infrastructure across the PPS will support the development and implementation of your cultural competency / health literacy strategy and the achievement of the milestones described above.

Information technology expectations include 1) the ability to identify and document additional socio-economic characteristics and health literacy status on intake and admissions fields to flag patient status for staff, care providers, and care givers and activate cultural competency/health literacy guidelines; 2) the ability to sort outcomes according to disparate population characteristics; and 3) use of the educational platform to offer, track and manage educational and training offerings. Additionally, information technology will develop the infrastructure to support a multi-pronged, multi-platform, and multi-lingual approach to improving patient health literacy and adherence to plans of care through patient engagement modalities such as text messaging of appointment reminder.

## IPQR Module 4.8 - Progress Reporting

**Instructions :**

Please describe how you will measure the success of this organizational workstream.

We will measure the success of this workstream by the timely completion of the milestones. We are also refining the demographic, socio-economic, and literacy assessment on the intake / process. These fields will trigger their respective guidelines for frontline workers and providers. Differentiating disparities more clearly will allow the PPS to sort and track clinical data according to disparate groups. Based on the results of baseline cultural competency assessments, we will develop an Organizational Cultural Competence Assessment Profile (prepared for the U.S. Department of Health and Human Services by The Lewin Group, Inc., 2002) to be used by the Seven Key Partners. This profile will outline the structure, process and output required to provide culturally competent care across seven domains (organizational values, governance, planning and monitoring/evaluation, communication, staff development, organizational infrastructure and services/interventions). It will serve as a roadmap for implementation and a tool for measuring progress. As described above, a cultural comp/health lit/engagement dashboard will also be developed. The dashboard will track process measures such as number of staff attending training, compliance with new admission assessment questions, and compliance with guidelines

## IPQR Module 4.9 - IA Monitoring

**Instructions :**

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### Section 05 – IT Systems and Processes

#### IPQR Module 5.1 - Prescribed Milestones

**Instructions :**

Please enter and update target dates, as well as breakdown tasks with target dates for prescribed milestones. For milestones that are due within the reporting period, documentation is required to provide evidence of milestone achievement.
Any explanations regarding altered or missed target commitments must be included within the textbox, not as narrative within uploaded documentation.

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| **Milestone #1**<br>Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s). | Completed | Detailed IT current state assessment. Relevant QEs (RHIOs/HIEs) should be involved in performing this assessment. | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | NO |
| **Task**<br>1) Perform IT Assessment and Issue Resolution Planning with PPS Partners related to existing technologies and overlap with DSRIP specific to EHR adoption and Meaningful Use, including current manual processes used; collaborate with PCMH accreditation process | Completed | 1) Perform IT Assessment and Issue Resolution Planning with PPS Partners related to existing technologies and overlap with DSRIP specific to EHR adoption and Meaningful Use, including current manual processes used; collaborate with PCMH accreditation process | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Task**<br>2) Review strategies needed for DSRIP specific Patient Engagement set by the DSRIP projects | Completed | 2) Review strategies needed for DSRIP specific Patient Engagement set by the DSRIP projects | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Task**<br>3) Perform IT Assessment and Issue Resolution Planning with PPS Partners related to existing technologies and overlap with DSRIP specific to Patient Engagement Tool and Strategies including patient portals, existing state-based tools (e.g., Curam), telehealth, and existing manual processes | Completed | 3) Perform IT Assessment and Issue Resolution Planning with PPS Partners related to existing technologies and overlap with DSRIP specific to Patient Engagement Tool and Strategies including patient portals, existing state-based tools (e.g., Curam), telehealth, and existing manual processes | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Task**<br>4) Perform current state assessment with Hixny specific to DSRIP reporting and connectivity | Completed | 4) Perform current state assessment with Hixny specific to DSRIP reporting and connectivity requirements to include: 1. Determine what data is available to support the DSRIP | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| requirements to include: 1. Determine what data is available to support the DSRIP reporting, 2. Determine what providers are connected to Hixny, 3. Determine how the data is currently captured and measures would be created (e.g., central vs. individual PPS partners) | | reporting, 2. Determine what providers are connected to Hixny, 3. Determine how the data is currently captured and measures would be created (e.g., central vs. individual PPS partners) | | | | | | | |
| **Task**<br>5) From gap analysis resulting from current state assessment, determine options for filling gaps including state-based tools (e.g., MAPP), RHIO (i.e., Hixny), and 3rd party solutions | Completed | 5) From gap analysis resulting from current state assessment, determine options for filling gaps including state-based tools (e.g., MAPP), RHIO (i.e., Hixny), and 3rd party solutions | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Milestone #2**<br>Develop an IT Change Management Strategy. | In Progress | IT change management strategy, signed off by PPS Board. The strategy should include:<br>-- Your approach to governance of the change process;<br>-- A communication plan to manage communication and involvement of all stakeholders, including users;<br>-- An education and training plan;<br>-- An impact / risk assessment for the entire IT change process; and<br>-- Defined workflows for authorizing and implementing IT changes | 04/01/2015 | 06/30/2016 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 | NO |
| **Task**<br>1) Create governance (e.g., committees, decision making process) for making IT decisions at two levels: the Alliance for Better Health Care and the PPS member levels | Completed | 1) Create governance (e.g., committees, decision making process) for making IT decisions at two levels: the Alliance for Better Health Care and the PPS member levels | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Task**<br>2) Perform data governance assessment including defining appropriate data stewards and tools for managing data specific to population health | In Progress | 2) Perform data governance assessment including defining appropriate data stewards and tools for managing data specific to population health | 04/01/2015 | 12/31/2015 | 12/31/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 | |
| **Task**<br>3) Develop an Education and Training Plan with the population health tool vendors specific to the new tools | In Progress | 3) Develop an Education and Training Plan with the population health tool vendors specific to the new tools | 04/01/2015 | 12/31/2015 | 12/31/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 | |
| **Task**<br>4) Develop a Communication Plan, including stakeholder analysis (including those within IT | Completed | 4) Develop a Communication Plan, including stakeholder analysis (including those within IT and those affected by IT) and matching stakeholders to appropriate communication | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| and those affected by IT) and matching stakeholders to appropriate communication method (e.g., newsletter, roadshows) to Inform all Stakeholders and Users | | method (e.g., newsletter, roadshows) to Inform all Stakeholders and Users | | | | | | | |
| **Task**<br>5) Develop a process for determining how success will be measured that incorporates feedback from practitioners and other key users of IT, including financial and patient engagement impact and risks | In Progress | 5) Develop a process for determining how success will be measured that incorporates feedback from practitioners and other key users of IT, including financial and patient engagement impact and risks | 04/01/2015 | 06/30/2016 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 | |
| **Task**<br>6) Develop a process for determining operational readiness of the PPS partners to implement the various changes | In Progress | 6) Develop a process for determining operational readiness of the PPS partners to implement the various changes | 04/01/2015 | 06/30/2016 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 | |
| **Task**<br>7) Develop a process for prioritizing changes needed, including appropriate governance and input from PPS membership | In Progress | 7) Develop a process for prioritizing changes needed, including appropriate governance and input from PPS membership | 04/01/2015 | 06/30/2016 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 | |
| **Task**<br>8) Develop a workflow process for authorizing and implementing IT changes leveraging governance structures | In Progress | 8) Develop a workflow process for authorizing and implementing IT changes leveraging governance structures | 04/01/2015 | 06/30/2016 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 | |
| **Milestone #3**<br>Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network | In Progress | Roadmap document, including current state assessment and workplan to achieve effective clinical data sharing and interoperable systems where required. The roadmap should include:<br>-- A governance framework with overarching rules of the road for interoperability and clinical data sharing;<br>-- A training plan to support the successful implementation of new platforms and processes; and<br>-- Technical standards and implementation guidance for sharing and using a common clinical data set<br>-- Detailed plans for establishing data exchange agreements between all providers within the PPS, including care management records (completed subcontractor DEAAs with all Medicaid providers within the PPS; contracts with all relevant CBOs including a BAA documenting the level of PHI to be shared and the purpose of this sharing). | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | NO |

# New York State Department Of Health
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## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| **Task** 1) Use IT Assessment to develop roadmap of tactical and strategic recommendations with high-level budget estimates and resource requirements to support data sharing and implementation of interoperable IT platform | Completed | 1) Use IT Assessment to develop roadmap of tactical and strategic recommendations with high-level budget estimates and resource requirements to support data sharing and implementation of interoperable IT platform | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Task** 2) Review IT Assessment based on the DSRIP project needs specific to new systems needed or changes to existing systems; note where RHIO connectivity is needed and/or new Electronic Health Record | In Progress | 2) Review IT Assessment based on the DSRIP project needs specific to new systems needed or changes to existing systems; note where RHIO connectivity is needed and/or new Electronic Health Record | 04/01/2015 | 12/31/2015 | 12/31/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task** 3) Identify prioritization of systems to build or associated change with separate work streams focused on implementing new Electronic Health Record Systems vs. RHIO connectivity based on the DSRIP project needs and associated providers' needs | In Progress | 3) Identify prioritization of systems to build or associated change with separate work streams focused on implementing new Electronic Health Record Systems vs. RHIO connectivity based on the DSRIP project needs and associated providers' needs | 04/01/2015 | 12/31/2015 | 12/31/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task** 4) Develop governance framework with overarching rules for road to interoperability and clinical data sharing | In Progress | 4) Develop governance framework with overarching rules for road to interoperability and clinical data sharing | 04/01/2015 | 12/31/2015 | 12/31/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task** 5) Validate existing data exchange legal and compliance framework to ensure that it supports DSRIP data exchange requirements that meet patient consent needs including: care management records (complete subcontractor Data Exchange Applications and Agreement (DEAAs) with all Medicaid providers within PPS; contracts with all Community Based Organizations (CBOs) including a BAA documenting the level of Patient Health Information (PHI) to be shared and the purpose of this data sharing | Completed | 5) Validate existing data exchange legal and compliance framework to ensure that it supports DSRIP data exchange requirements that meet patient consent needs including: care management records (complete subcontractor Data Exchange Applications and Agreement (DEAAs) with all Medicaid providers within PPS; contracts with all Community Based Organizations (CBOs) including a BAA documenting the level of Patient Health Information (PHI) to be shared and the purpose of this data sharing | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task** 6) Determine technical standards and | In Progress | 6) Determine technical standards and implementation guidance for sharing and using a common clinical data set | 04/01/2015 | 12/31/2015 | 12/31/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| implementation guidance for sharing and using a common clinical data set through Electronic Health Records and/or other PHM tools | | through Electronic Health Records and/or other PHM tools | | | | | | | |
| **Task** 7) Perform gap analysis and develop associated roadmap of data types and content required to support DSRIP project requirements compared to current and planned data from HIXNY | In Progress | 7) Perform gap analysis and develop associated roadmap of data types and content required to support DSRIP project requirements compared to current and planned data from HIXNY | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task** 8) Perform gap analysis and develop associated roadmap of interoperability and integration needs between HIXNY and selected tools (including PHM and EHR) | In Progress | 8) Perform gap analysis and develop associated roadmap of interoperability and integration needs between HIXNY and selected tools (including PHM and EHR) | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task** 9) Conduct proof of concept/IT systems testing to validate capability to achieving clinical data sharing and interoperable systems across PPS network | In Progress | 9) Conduct proof of concept/IT systems testing to validate capability to achieving clinical data sharing and interoperable systems across PPS network | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task** 10) Develop a roll-out plan for systems to achieve clinical data sharing, including a training plan to support the successful implementation of new platforms and processes | In Progress | 10) Develop a roll-out plan for systems to achieve clinical data sharing, including a training plan to support the successful implementation of new platforms and processes | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Milestone #4** Develop a specific plan for engaging attributed members in Qualifying Entities | In Progress | PPS plan for engaging attributed members in Qualifying Entities, signed off by PPS Board. The plan should include your approach to outreach into culturally and linguistically isolated communities. | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 | NO |
| **Task** 1) Review and incorporate attribution methodology for attributed lives to define which providers should engage which members | In Progress | 1) Review and incorporate attribution methodology for attributed lives to define which providers should engage which members | 04/01/2015 | 12/31/2015 | 12/31/2015 | 09/30/2016 | 09/30/2016 | DY2 Q2 | |
| **Task** 2) Define member segments and associated specific engagement needs (e.g., geo-access assessment, cultural/linguistic needs); develop segment specific to different patient behavior needs: patients who do not use services appropriately as opposed to patients who need | In Progress | 2) Define member segments and associated specific engagement needs (e.g., geo-access assessment, cultural/linguistic needs); develop segment specific to different patient behavior needs: patients who do not use services appropriately as opposed to patients who need reminders to go to an appointment with the PCP | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| reminders to go to an appointment with the PCP | | | | | | | | | |
| **Task**<br>3) Determine appropriate methods and incremental technological services needed for engaging patients and delivering care (e.g., patient portal, text messages) for different member segments | In Progress | 3) Determine appropriate methods and incremental technological services needed for engaging patients and delivering care (e.g., patient portal, text messages) for different member segments | 04/01/2015 | 06/30/2016 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 | |
| **Task**<br>4) Incorporate different member segments needs in selecting appropriate technologies | In Progress | 4) Incorporate different member segments needs in selecting appropriate technologies | 04/01/2015 | 06/30/2016 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 | |
| **Task**<br>5) Develop appropriate, multi-lingual patient education materials and content and disseminate using appropriate communication methods (e.g. Patient portal, text messages) | In Progress | 5) Develop appropriate, multi-lingual patient education materials and content and disseminate using appropriate communication methods (e.g. Patient portal, text messages) | 04/01/2015 | 09/30/2016 | 04/01/2015 | 09/30/2016 | 09/30/2016 | DY2 Q2 | |
| **Task**<br>6) Conduct proof of concept to validate patient engagement strategy and appropriate technology solutions | In Progress | 6) Conduct proof of concept to validate patient engagement strategy and appropriate technology solutions | 04/01/2015 | 12/31/2016 | 04/01/2015 | 12/31/2016 | 12/31/2016 | DY2 Q3 | |
| **Task**<br>7) Develop plan for technology rollout and patient engagement to match different patient segment engagement needs based upon proof of concept results | In Progress | 7) Develop plan for technology rollout and patient engagement to match different patient segment engagement needs based upon proof of concept results | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 | |
| **Milestone #5**<br>Develop a data security and confidentiality plan. | In Progress | Data security and confidentiality plan, signed off by PPS Board, including:<br>-- Analysis of information security risks and design of controls to mitigate risks<br>-- Plans for ongoing security testing and controls to be rolled out throughout network. | 04/01/2015 | 12/31/2016 | 04/01/2015 | 12/31/2016 | 12/31/2016 | DY2 Q3 | NO |
| **Task**<br>1) Create data security and confidentiality committee | Completed | 1) Create data security and confidentiality committee | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Task**<br>2) Conduct assessment of data security and information controls using survey | In Progress | 2) Conduct assessment of data security and information controls using survey | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task**<br>3) Document and validate plans and policies in | In Progress | 3) Document and validate plans and policies in line with all applicable regulations (e.g., Regulatory Issues Policies, | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| line with all applicable regulations (e.g., Regulatory Issues Policies, Consumer Privacy, Technical and Physical) at all existing PPS partners | | Consumer Privacy, Technical and Physical) at all existing PPS partners | | | | | | | |
| **Task** 4) Document and validate the data breach reporting policy for each of the PPS partners; ensure alignment with all applicable regulations | In Progress | 4) Document and validate the data breach reporting policy for each of the PPS partners; ensure alignment with all applicable regulations | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task** 5) Identify Data Security contacts at each PPS partner and review data security and information control survey results and determine associated remediation plans | In Progress | 5) Identify Data Security contacts at each PPS partner and review data security and information control survey results and determine associated remediation plans | 04/01/2015 | 06/30/2016 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 | |
| **Task** 6) Establish an appropriate review process if a PPS partner determines that there is a data breach | In Progress | 6) Establish an appropriate review process if a PPS partner determines that there is a data breach | 04/01/2015 | 12/31/2016 | 04/01/2015 | 12/31/2016 | 12/31/2016 | DY2 Q3 | |
| **Task** 7) Establish an escalation path to the executive governance group for the PPS if a PPS partner determines that there is a data breach that must be resolved for the PPS as a whole | In Progress | 7) Establish an escalation path to the executive governance group for the PPS if a PPS partner determines that there is a data breach that must be resolved for the PPS as a whole | 04/01/2015 | 12/31/2016 | 04/01/2015 | 12/31/2016 | 12/31/2016 | DY2 Q3 | |
| **Task** 8) Develop plan for ongoing security testing and controls across network | In Progress | 8) Develop plan for ongoing security testing and controls across network | 04/01/2015 | 12/31/2016 | 04/01/2015 | 12/31/2016 | 12/31/2016 | DY2 Q3 | |

### IA Instructions / Quarterly Update

| Milestone Name | IA Instructions | Quarterly Update Description |
|---|---|---|

No Records Found

### Prescribed Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|
| Develop a data security and confidentiality plan. | mccarrol | Documentation/Certification | 3_MDL0503_1_3_20160202121413_DY1Q3_Interim_Security_Plan_Submission.pdf | DY1Q3 Interim Security Plan Submission | 02/02/2016 12:14 PM |

### NYS Confidentiality – High

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Prescribed Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|
| Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s). | |
| Develop an IT Change Management Strategy. | Tasks 2 and 3 originally scheduled for 12/31/2015 have been changed to 6/30/2016 to reflect the ongoing nature of the work. |
| Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network | Tasks 2, 3, 4, and 6, originally scheduled for 12/31/2015 have been moved to 3/31/2016 to reflect the ongoing nature of the work. |
| Develop a specific plan for engaging attributed members in Qualifying Entities | Task 1, originally scheduled for 12/31/2015 has been moved to 9/30/2016 to reflect the ongoing nature of the work. |
| Develop a data security and confidentiality plan. | DY1Q3 Alliance Remediation response: No response required per IA. |

### Milestone Review Status

| Milestone # | Review Status | IA Formal Comments |
|---|---|---|
| **Milestone #1** | Pass & Ongoing | |
| **Milestone #2** | Pass & Ongoing | |
| **Milestone #3** | Pass & Ongoing | |
| **Milestone #4** | Pass & Ongoing | |
| **Milestone #5** | Pass & Ongoing | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 5.2 - PPS Defined Milestones

**Instructions :**

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones.

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|

No Records Found

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 5.3 - Major Risks to Implementation & Risk Mitigation Strategies

**Instructions :**

Please describe the key challenges or risks that you foresee in creating and implementing your IT governance structure, your plans for data sharing across your network, your approach to data security and confidentiality, and the achievement of the milestones described above, including the potential impacts on specific projects and any risks that will undermine your ability to achieve outcome measure targets.

Timely and appropriate access to the appropriate data (e.g., claims, clinical data) through data latency or Vendors not using interoperability standards, which we will mitigate by working with global standards and the RHIO's existing connections, as well as leveraging existing claims data feeds from the State 2) Difficulty of actionable quality data at Point of Care which we will mitigate by leveraging existing Point of Care workflow tools or using solutions that have proven capabilities to work at the Point of Care 3) Patient churn/lack of visibility into patient's longer-term health, which we will resolve with our own Health Risk Assessment tools to collect detailed patient history 4)Reliance upon HIXNY/RHIO to provide interoperable IT platform which we will mitigate through working with HIXNY/RHIO to develop needed functionality 5) Provider confusion as all providers will be facing significant new initiatives in the community which include the IHANY ACO, Albany Medical Center PPS, and AFBHC PPS which we will mitigate through governance 6)Lack of technology adoption throughout the PPS which we will mitigate by investigating and providing technology solutions as needed to the PPS partners who have a need 7)Reliance upon NY state to provide sufficient patient consent and data compliance laws to enable sufficient combination, viewing, and usage of patient information 8)Reliance upon RHIO to provide interconnectivity and other iT functions in a timely manner which we will mitigate by involving the RHIO in our planning process

### IPQR Module 5.4 - Major Dependencies on Organizational Workstreams

**Instructions :**

Please describe any interdependencies with other organizational workstreams (IT Systems and Processes, Clinical Integration, etc.)

IT infrastructure is required for Clinical Integration, Practitioner Engagement, Performance Reporting, Population Health Management. IT Systems and Processes is dependent upon effective training, implementation, and PMO. Making sufficient investments in technology to support patient engagement and other program goals is dependent upon the PPS making the appropriate budget provided by meeting the overall DSRIP goals.

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 5.5 - Roles and Responsibilities

**Instructions :**

Please list and elaborate upon the key people/organizations responsible for this organizational workstream and describe what their responsibilities involve.

| Role | Name of person / organization (if known at this stage) | Key deliverables / responsibilities |
|---|---|---|
| Committee co-chair | Joe Gambino | Overall leadership |
| Committee co-chair | Jon Goldberg | Overall leadership |
| Analytics Lead | In Progress | Overall leadership for reporting, data aggregation, and dashboard design |
| Hometown Health representatives | Julie Greco/Eric Burton | Ensure completion of current state analysis and roadmap to clinical data sharing, represent change management processes needed at , and validate ability to receive data securely at PPS member organization |
| St. Mary's Healthcare Amsterdam representatives | Michael Reynolds/Jim Degroff/Tina O'Hanlon | Ensure completion of current state analysis and roadmap to clinical data sharing, represent change management processes needed at , and validate ability to receive data securely at PPS member organization |
| Capital Care representative | Charles Hagstrand | Ensure completion of current state analysis and roadmap to clinical data sharing, represent change management processes needed at , and validate ability to receive data securely at PPS member organization |
| St. Peter's Health Partners representatives | Karen LeBlanc/Will Rauch | Ensure completion of current state analysis and roadmap to clinical data sharing, represent change management processes needed at , and validate ability to receive data securely at PPS member organization |
| Whitney Young representative | Mary Connolly | Ensure completion of current state analysis and roadmap to clinical data sharing, represent change management processes needed at , and validate ability to receive data securely at PPS member organization |
| Ellis representative | Dr. Bachwani | Ensure completion of current state analysis and roadmap to clinical data sharing, represent change management processes needed at , and validate ability to receive data securely at PPS member organization |
| Rensselaer County Department of Mental Health representative | Shephard | Ensure completion of current state analysis and roadmap to clinical data sharing, represent change management processes needed at , and validate ability to receive data securely specific to Rensselaer County mental health institutions |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Role | Name of person / organization (if known at this stage) | Key deliverables / responsibilities |
|---|---|---|
| Data security committee chair | Adam Dodge | Providing policies and support related to data compliance and security; data security and confidentiality plan |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 5.6 - Key Stakeholders

**Instructions :**

Please identify the key stakeholders involved, both within and outside the PPS.

| Key stakeholders | Role in relation to this organizational workstream | Key deliverables / responsibilities |
|---|---|---|
| **Internal Stakeholders** | | |
| Tom McCarroll | VP of Performance Operations (Interim) | Overall IT decisions |
| Brenda Maynor | VP of Clinical Operations (Interim) | Clinical IT decisions |
| Olga Dazzo | Acting CEO | Ensuring IT decisions are in accordance with overall strategy |
| Dr. Kraev | Physician IT Committee | Provide IT requirements for DSRIP programs from a physician's perspective |
| Dr. Bachwani | Physician IT Committee | Provide IT requirements for DSRIP programs from a physician's perspective |
| PPS members' EMR representatives | Contributor | Roadmap for delivering interoperable IT platform, specific plan for engaging attributed members |
| Board of Managers | Approver | Roadmap for delivering interoperable IT platform, specific plan for engaging attributed members, IT Change Management Strategy |
| **External Stakeholders** | | |
| HIXNY representative | Contributor | Roadmap for delivering interoperable IT platform, data security and confidentiality plan |
| Population health tool representatives | Contributor | Roadmap for delivering interoperable IT platform, specific plan for engaging attributed members, IT Change Management Strategy |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 5.7 - Progress Reporting

**Instructions :**

Please describe how you will measure the success of this organizational workstream.

The AFBHC PMO will utilize project management, population health, board management, and accounting software to manage the PPS infrastructure and projects. The project management tool will clearly define milestones, steps, and timing expectations, and be reported monthly utilizing a balanced score card approach for all committees. The balance score card approach will identify risks, performance and financial trends, and expectations by function and project to align with accountable PPS stakeholders. The AFBHC PMO will release the balance score card on a regular basis that is dictated by this implementation plan but no later than every quarter. For IT Systems and Processes, the balance score card will track metrics such as meaningful use of EHRs, adoption of certified PCMH standards, and patient engagement. Within the implementation period, the AFBHC PMO will track and report on progress related to tool implementation and configuration, the roadmap to achieving clinical data sharing and interoperable systems across PPS network, and the overall IT change management strategy. To assist the AFBHC, reporting will be done on two levels: the overall PPS and the individual PPS member to promote compliance. The individual PPS members will share information through their own current communication processes. External stakeholders will have appropriate access to the progress reporting as well.

### IPQR Module 5.8 - IA Monitoring

**Instructions :**

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Section 06 – Performance Reporting

#### IPQR Module 6.1 - Prescribed Milestones

**Instructions :**

Please enter and update target dates, as well as breakdown tasks with target dates for prescribed milestones. For milestones that are due within the reporting period, documentation is required to provide evidence of milestone achievement.
Any explanations regarding altered or missed target commitments must be included within the textbox, not as narrative within uploaded documentation.

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| **Milestone #1**<br>Establish reporting structure for PPS-wide performance reporting and communication. | In Progress | Performance reporting and communications strategy, signed off by PPS Board. This should include:<br>-- The identification of individuals responsible for clinical and financial outcomes of specific patient pathways;<br>-- Your plans for the creation and use of clinical quality & performance dashboards<br>-- Your approach to Rapid Cycle Evaluation | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 | NO |
| **Task**<br>1. Establish reporting structure for PPS wide-performance reporting and communication. | Completed | 1. Establish reporting structure for PPS wide-performance reporting and communication. | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task**<br>2. Develop Rapid Cycle Evaluation team dedicated to the understanding, data interpretation, and dissemination of all milestones and metrics associated with Domains 2, 3, and 4 and its relationship to performance and revenue. | Completed | 2. Develop Rapid Cycle Evaluation team dedicated to the understanding, data interpretation, and dissemination of all milestones and metrics associated with Domains 2, 3, and 4 and its relationship to performance and revenue. | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task**<br>3. Identify required Domains 2, 3, and 4 metrics defining Measure Steward, Data Sources, and timelines for reporting and performance. | Completed | 3. Identify required Domains 2, 3, and 4 metrics defining Measure Steward, Data Sources, and timelines for reporting and performance. | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task**<br>4. Define clinical and financial performance key performance indicators with PPS-wide executive leadership beyond DSRIP. | Completed | 4. Define clinical and financial performance key performance indicators with PPS-wide executive leadership beyond DSRIP. | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task**<br>5. Determine necessary functions and associated | In Progress | 5. Determine necessary functions and associated tools for combining state-supplied data with PPS-collected data. | 04/01/2015 | 12/31/2015 | 12/31/2015 | 09/30/2016 | 09/30/2016 | DY2 Q2 | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| tools for combining state-supplied data with PPS-collected data. Determine technology needed for reporting and management. | | Determine technology needed for reporting and management. | | | | | | | |
| **Task** 6. Perform a current state assessment of existing reporting processes across the PPS and define target state outcomes. | Completed | 6. Perform a current state assessment of existing reporting processes across the PPS and define target state outcomes. | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task** 7. Identify specific persons or positions in the network that will be responsible for submitting required data to the PPS for analytics and subsequent reporting for each metric, milestone, and project requirements. | Completed | 7. Identify specific persons or positions in the network that will be responsible for submitting required data to the PPS for analytics and subsequent reporting for each metric, milestone, and project requirements. | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task** 8. Establish process for communicating state-provided data (accessed through the MAPP Tool) to providers through existing templates and Excel files as a short-term solution | In Progress | 8. Establish process for communicating state-provided data (accessed through the MAPP Tool) to providers through existing templates and Excel files as a short-term solution | 04/01/2015 | 12/31/2015 | 12/31/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 | |
| **Task** 9. Engage with finance to determine the fund flow and incentive payment implications of performance reporting | In Progress | 9. Engage with finance to determine the fund flow and incentive payment implications of performance reporting | 04/01/2015 | 12/31/2015 | 12/31/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 | |
| **Task** 10. Design first draft dashboards and reports so that they may be decentralized and rolled up at the project level, across projects, individual provider and group level, for PPS as a whole. | In Progress | 10. Design first draft dashboards and reports so that they may be decentralized and rolled up at the project level, across projects, individual provider and group level, for PPS as a whole. | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task** 11. Develop performance reporting dashboards, with different levels of detail for reports to the Project Management Office (PMO), the Board, and the PPS providers. | In Progress | 11. Develop performance reporting dashboards, with different levels of detail for reports to the Project Management Office (PMO), the Board, and the PPS providers. | 04/01/2015 | 09/30/2016 | 04/01/2015 | 09/30/2016 | 09/30/2016 | DY2 Q2 | |
| **Task** 12. Hold training sessions with providers to review performance reporting dashboards with different types of providers and provide providers ability to run reports themselves | In Progress | 12. Hold training sessions with providers to review performance reporting dashboards with different types of providers and provide providers ability to run reports themselves | 04/01/2015 | 12/31/2016 | 04/01/2015 | 12/31/2016 | 12/31/2016 | DY2 Q3 | |
| **Task** | In Progress | 13. Hold town halls/rolling meetings with providers to review | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| 13. Hold town halls/rolling meetings with providers to review initial DSRIP performance report reviews | | initial DSRIP performance report reviews | | | | | | | |
| **Milestone #2**<br>Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting. | In Progress | Finalized performance reporting training program. | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | NO |
| **Task**<br>1. Identify role of provider types in projects, reporting, decision-making needs, revenue generation, and dashboards. | In Progress | 1. Identify role of provider types in projects, reporting, decision-making needs, revenue generation, and dashboards. | 04/01/2015 | 12/31/2015 | 12/31/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task**<br>2. Identify appropriate curriculums tailored to each provider type with respective identified needs. | In Progress | 2. Identify appropriate curriculums tailored to each provider type with respective identified needs. | 04/01/2015 | 12/31/2015 | 12/31/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task**<br>"3. Identify specific themes to be included in the training program:<br>a. Success factors in a training program associated with the use of performance data<br>b. The role played by function-specific and project-specific leadership<br>c. The role of performance reporting in creating accountability<br>" | In Progress | "3. Identify specific themes to be included in the training program:<br>a. Success factors in a training program associated with the use of performance data<br>b. The role played by function-specific and project-specific leadership<br>c. The role of performance reporting in creating accountability<br>" | 04/01/2015 | 12/31/2015 | 12/31/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task**<br>4. Define performance reporting training program, including process for follow-up training and continuous quality improvement related to performance reporting | In Progress | 4. Define performance reporting training program, including process for follow-up training and continuous quality improvement related to performance reporting | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task**<br>5. Develop training program that incorporates how the performance model incorporates into the value-based payment model and how performance can impact payment | In Progress | 5. Develop training program that incorporates how the performance model incorporates into the value-based payment model and how performance can impact payment | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IA Instructions / Quarterly Update

| Milestone Name | IA Instructions | Quarterly Update Description |
|---|---|---|

No Records Found

### Prescribed Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|

No Records Found

### Prescribed Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|
| Establish reporting structure for PPS-wide performance reporting and communication. | Tasks 5 and 8, originally scheduled for 12/31 have been moved to 9/30/2016 to reflect the ongoing nature of the work.<br>Task 9, originally scheduled for 12/31 has been moved to 6/30/2016 to reflect the ongoing nature of the work. |
| Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting. | Tasks 1, 2, and 3, originally scheduled for 12/31/2015 have been moved to 3/31/206 to reflect the ongoing nature of the work. |

### Milestone Review Status

| Milestone # | Review Status | IA Formal Comments |
|---|---|---|
| **Milestone #1** | Pass & Ongoing | |
| **Milestone #2** | Pass & Ongoing | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 6.2 - PPS Defined Milestones

**Instructions :**

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones.

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|

No Records Found

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 6.3 - Major Risks to Implementation & Risk Mitigation Strategies

**Instructions :**

Please describe the key challenges or risks that you foresee in implementing performance reporting structures and processes and effective performance management within your network, including potential impacts on specific projects and any risks that will undermine your ability to achieve outcome measure targets.

1) Practitioner alienation if the performance reporting is not accurate, which we will mitigate through appropriate practitioner involvement and review of metrics and patient attribution.
2) IT Risks: Data Interoperability dependent upon working with multiple vendors that may not support existing standards; risk mitigation strategy is to engage vendors early and determine supplemental solutions where available.
3) There is risk that information reporting may not be uniform or available at the same time across the network therefore creating a division in the network. This risk will be mitigated by carefully selecting the rollout of reports.
4) There is a risk of selecting many more metrics for improvement than the network could possibly address in a given time period which could result in not achieving any of the stated metric goals. This risk will be mitigated by carefully selecting and prioritizing achievable metrics for improvement per given time periods

### IPQR Module 6.4 - Major Dependencies on Organizational Workstreams

**Instructions :**

Please describe any interdependencies with other organizational workstreams (IT Systems and Processes, Clinical Integration, etc.)

IT Systems and Processes: Completion of the milestones titled "Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network", "Develop a data security and confidentiality plan", and "Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s)";
Practitioner Engagement: Engaging the right set of practitioner leaders across the entire PPS is critical as reliability/believability within the Performance Reports is paramount for success;
Financial Sustainability: The establishment of financial flows and specific contracts to support VBP is a pre-requisite for establishing effective Performance Reporting as Performance Reporting must reflect all of the required metrics of a contract and effectively incentivize performance with practitioners;
Governance: The establishment of proper governance (e.g., physician leadership clusters, hubs) is critical for Performance Reporting as it establishes the categorizations for which performance reporting must adhere.

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 6.5 - Roles and Responsibilities

**Instructions :**

Please list and elaborate upon the key people/organizations responsible for this organizational workstream and describe what their responsibilities involve.

| Role | Name of person / organization (if known at this stage) | Key deliverables / responsibilities |
|---|---|---|
| IT & Data Committee | CIOs from Board of Manager entities, RHIO, and other providers | Oversight of reporting process from an IT perspective. Oversight of the development and implementation of technology plan to ensure the support for clinical workflows and timely and safe exchange of patient information. |
| Clinical Integration and Quality Committee and Project Steering Subcommittees | Clinical representatives from Board of Managers entities plus other community based organizations | Adoption of evidence based practices and protocols consistent across all projects and intended to be used uniformly by specific provider types across the network. |
| Compliance Officer | Colleen Susko | Ensure that reporting is accurate and complies with all laws and regulations |
| Rapid Cycle Evaluation Team | In Progress | Prompt evaluation of results and trend detection; timely communication to stakeholders |
| AFBHC Information Technology leader and technical staff | In Progress | Implementation of AFBHC Technology Plan; ensure operational performance |
| Initial Project Leads from Partner Entities | Joe Twardy, Pamela Rehak, Scott Friedlander, Brenda Maynor, Erin Simao, Dave Shippee, Patrick Carrese, Keith Brown, Kathy Ristau, Kevin Jobin-Davis, Rachel Handler, Millie Ferriter, Kathy Alonge-Coons, Amanda Mulhern | Shepherd projects through early phases of planning, development, and implementation |
| AFBHC Project lead for 2.b.iii, 2.b.iv, 3.g.i | Scott Friedlander (Interim) | Implement AFBHC projects throught the central AFBHC Clinical Operations office in close collaboration with partner entities |
| AFBHC Project lead for 2.d.i | Erin Simao (Interim) | Implement AFBHC projects throught the central AFBHC Clinical Operations office in close collaboration with partner entities |
| AFBHC Project Leads for 2.a.i, 2.b.viii, 3.a.i, 3.a.iv, 3.d.ii, 4.a.iii, 4.b.i | In Progress | Implement AFBHC projects throught the central AFBHC Clinical Operations office in close collaboration with partner entities |
| VP of Performance Operations | Tom McCarroll (Interim)/AFBHC Performance Office | Provide guidance and oversight for the Performance Operations of AFBHC |
| VP of Clinical Operations | Brenda Maynor (Interim)/AFBHC Clinical Office | Provide guidance and oversight for the Clinical Operations of AFBHC |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 6.6 - Key Stakeholders

**Instructions :**

Please identify the key stakeholders involved, both within and outside the PPS.

| Key stakeholders | Role in relation to this organizational workstream | Key deliverables / responsibilities |
|---|---|---|
| **Internal Stakeholders** | | |
| Board of Managers | Collaborate with organizations for positive outcomes | Spearhead performance reporting metrics reports, dashboards, communication |
| IT Staff within individual provider organizations | Reporting and IT System maintenance | Monitor, tech support, upgrade of IT and reporting systems. |
| Providers | Organizations immediately responsible for delivering on the performance monitoring processes established across the PPS. | "Promote culture of excellence<br>Employ standardized care practices to improve patient care outcomes." |
| Finance Committee | Oversee financial responsibilities | Determine the financial implications of performance reports |
| **External Stakeholders** | | |
| Patient representative for performance reporting and their organizations | Provide patient feedback to support performance monitoring and performance improvement | Input into performance monitoring and continuous performance improvement processes |
| HIXNY | Data and information sharing | Monitor, tech support, upgrade of IT and reporting systems. |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 6.7 - IT Expectations

**Instructions :**

Please clearly describe how the development of shared IT infrastructure across the PPS will support your approach to performance reporting.

A shared IT infrastructure must be in place to provide the data to support accurate performance reporting across the entire PPS. Specific expectations include the need to connect across disparate systems, and capture data from the different modalities of care. Performance reporting will rely upon the IT stems to capture the right data at the right time across all PPS partners to ensure accurate and reliable reporting.

### IPQR Module 6.8 - Progress Reporting

**Instructions :**

Please describe how you will measure the success of this organizational workstream.

The AFBHC Project Management Office (PMO) will utilize project management, population health, board management, and accounting software to manage the PPS infrastructure and projects. The project management tool will clearly define milestones, steps, and timing expectations, and be reported monthly utilizing a balanced score card approach for all committees. The balance score card approach will identify risks, performance and financial trends, and expectations by function and project to align with accountable PPS stakeholders. For Performance Reporting, the focus will be on the development and progress on the metrics included in the balance scorecard. To assist the AFBHC, reporting will be done on multiple levels to promote compliance including the project level, across projects, individual provider and group level, and the PPS as a whole.. The individual PPS members will share information through their own current communication processes and the PPS will establish a communication protocol appropriate for keeping all stakeholders and the workforce engaged. External stakeholders will have appropriate access to the progress reporting as well.

### IPQR Module 6.9 - IA Monitoring

**Instructions :**

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

## Section 07 – Practitioner Engagement

### IPQR Module 7.1 - Prescribed Milestones

**Instructions :**

Please enter and update target dates, as well as breakdown tasks with target dates for prescribed milestones. For milestones that are due within the reporting period, documentation is required to provide evidence of milestone achievement.
Any explanations regarding altered or missed target commitments must be included within the textbox, not as narrative within uploaded documentation.

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| **Milestone #1**<br>Develop Practitioners communication and engagement plan. | Completed | Practitioner communication and engagement plan. This should include:<br>-- Your plans for creating PPS-wide professional groups / communities and their role in the PPS structure<br>-- The development of standard performance reports to professional groups<br>--The identification of profession / peer-group representatives for relevant governing bodies, including (but not limited to) Clinical Quality Committee | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | NO |
| **Task**<br>1. Establish Practitioner Engagement Task Force, subject to the committee and task force evaluation that is being conducted to ensure there is alignment with IHANY and that there is minimal duplication so that practitioners are not burdened. (Refer to Governance, Milestone: Finalize governance structure and sub-committee structure (4.a). | Completed | "a. Identify practitioner leaders/champions to co-chair the Practitioner Engagement Task Force<br>b. Recruit practitioner members to Task Force<br>c. Write expectations and goals of Task Force<br>d. Ask co-chairs to participate and meet to review goals<br>e. Identify facilitator<br>" | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Task**<br>2. Develop practitioner communication and engagement plan | Completed | a. Identify role each provider type will play in projects<br>b. Identify common communication needs for all providers<br>c. Identify specific communication needs by provider type<br>d. Develop PPS-wide professional groups<br>e. Identify standard professional reports by provider types<br>f. Identify timetable for needed communications, tailoring the communication by phase of project implementation<br>g. Identify best methods of communication by provider types<br>h. Develop implementation plan, including content | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| | | i. Present draft plan to relevant committees/groups | | | | | | | |
| **Task**<br>3. Begin implementation of communication and engagement plan | Completed | 3. Begin implementation of communication and engagement plan | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Milestone #2**<br>Develop training / education plan targeting practioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda. | In Progress | Practitioner training / education plan. | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | NO |
| **Task**<br>1. Begin to schedule visits with physician groups and other practitioners to teach about general themes, e.g., DSRIP and how DSRIP will help practitioners and Medicaid members, Project Requirements and Implementation overview, AFBHC population health management model, and other general topics to begin the engagement process. | Completed | 1. Begin to schedule visits with physician groups and other practitioners to teach about general themes, e.g., DSRIP and how DSRIP will help practitioners and Medicaid members, Project Requirements and Implementation overview, AFBHC population health management model, and other general topics to begin the engagement process. | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Task**<br>2. Develop practitioner training/education plan | In Progress | "a. Develop curriculum with general and specific content for provider types to educate and incorporate assessment findings<br>b. Include in the training program how each project impacts DSRIP Domains 2, 3, and 4 metrics and goals and in turn how each physician/practitioner impacts goals with subsequent potential earnings through funds flow policy.<br>c. Identify frequency of training throughout the life of the DSRIP projects and beyond, target training content to the life cycle of each project<br>d. Consider qualifying curriculum for continuing education credits<br>e. Submit draft training/education plan to Workforce Committeee. Present training/education plan to other relevant committees/groups<br>f. Develop survey of practitioners to assess their satisfaction with the type and amount of engagement from the PPS<br>" | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task** | In Progress | 3. Schedule training programs by provider types | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| 3. Schedule training programs by provider types | | | | | | | | | |

### IA Instructions / Quarterly Update

| Milestone Name | IA Instructions | Quarterly Update Description |
|---|---|---|

No Records Found

### Prescribed Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|
| Develop Practitioners communication and engagement plan. | mccarrol | Documentation/Certification | 3_MDL0703_1_3_20160315143241_DY1Q3_remediation_Project_specific_summaries.pdf | Project specific summaries | 03/15/2016 02:32 PM |
| | mccarrol | Documentation/Certification | 3_MDL0703_1_3_20160315143207_DY1Q3_remediation_Alliance_Project_Specific_Dashboards_11_17.xlsx | Alliance project specific dashboards | 03/15/2016 02:32 PM |
| | mccarrol | Documentation/Certification | 3_MDL0703_1_3_20160129135733_Practitioner_Communication_and_Engagement_Plan.docx | Practitioner Communication and Engagement Plan. | 01/29/2016 01:57 PM |

### Prescribed Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|
| Develop Practitioners communication and engagement plan. | DY1Q3 Alliance Remediation response: As DSRIP evolves Alliance will continue to refine and develop performance reports that will allow providers to understand efforts to achieve gap-to-goal requirements. Presently Alliance utilizes two primary reports for this purpose; (1) Project specific summaries, and (2) Project specific dashboards. These reports have been uploaded into MAPP:<br><br>1. Project specific summaries: These summary reports include a listing of all project requirements and have been shared with the relevant multi-disciplinary project work groups, as well as with the Clinical Integration and Quality Committee, the project specific quality sub-committees, and to providers that were part of the initial distribution of funds as part of Alliance's Participation Agreement – execution of which was required to release funds.<br>2. Project specific dashboards: These project specific dashboard reports provide performance specific payment and gap-to-goal data. These project specific dashboards have been shared with the relevant multi-disciplinary project work groups, as well as with the Clinical Integration and Quality Committee and project specific quality sub-committees.<br><br>Copies of these reports have been uploaded into MAPP at Practitioner Engagement Milestone #1. |
| Develop training / education plan targeting practioners and | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Prescribed Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|
| other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda. | |

### Milestone Review Status

| Milestone # | Review Status | IA Formal Comments |
|---|---|---|
| **Milestone #1** | Pass & Complete | |
| **Milestone #2** | Pass & Ongoing | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 7.2 - PPS Defined Milestones

**Instructions :**

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones.

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|

No Records Found

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 7.3 - Major Risks to Implementation & Risk Mitigation Strategies

**Instructions :**

Please describe the current level of engagement of your physician community in the DSRIP program and describe the key challenges or risks that you foresee in implementing your plans for physician engagement and achieving the milestones described above. Describe any potential impacts on specific projects and any risks that will undermine your ability to achieve outcome measure targets.

Due to the fast pace of DSRIP development, practitioners may not be fully aware of the intricacies of the projects and the positive effects they will have in spearheading the transformation of health care. Lack of awareness about DSRIP is a risk that will be mitigated through inclusion and communication with front line primary care physicians and other front-line practitioners. Other initiatives will be considered to mitigate this risk, such as inclusion of provider groups/types in the development of clinical best practices/protocols, development of annual goals, holding annual performance awards, sponsoring quality improvement summits within the PPS and holding collaborative sprints on subjects of professional groups' interest that tie to projects. Another risk to the successful engagement of all practitioners is the lack of integration of medical and behavioral health records throughout the alliance. Since this ties directly with the IT requirements, road maps for IT systems and processes with be followed to ensure interoperability, which will engage practitioners with simplified connectivity.

### IPQR Module 7.4 - Major Dependencies on Organizational Workstreams

**Instructions :**

Please describe any interdependencies with other organizational workstreams (IT Systems and Processes, Clinical Integration, etc.)

Given that this workstream is about communication, it impacts all organizational sections and project plans. Key aspects of each organizational section and project plans will be incorporated into the content of the communication and training programs. Communicating with 1,400 providers across six counties will be a challenge that will be carefully considered during the assessment and communication planning processes. Other workstreams will be leveraged to assist in provider engagement. For example IT benefits that will be offered practitioners, incentive programs, and workforce license innovations will be highlighted and used in the communication and training programs with practitioners.

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 7.5 - Roles and Responsibilities

**Instructions :**

Please list and elaborate upon the key people/organizations responsible for this organizational workstream and describe what their responsibilities involve.

| Role | Name of person / organization (if known at this stage) | Key deliverables / responsibilities |
|---|---|---|
| AFBHC Practitioner Engagement Task Force | "In Progress, will include the CMOs of the key partners of AFBHC: Capital Care (Lou Snitkof, M. D.), Community Care (Barbara Morris, M. D.), St. Mary's (Bill Mayer, M. D.), Ellis (Roger Barrowman, M. D.), St. Peter's (Dr. Cella, Dr. Silverman and Dr. T. Lawrence), Hometown Health (David Skory, M.D.), Whitney Young (Theodore Zeltner, M. D.) " | Be ambassadors for engagement. Guide the assessment, development of communication and engagement plan, training program development, and other practitioner engagement processes. |
| Medical Director | John Collins, MD | Promote practitioner engagement and ensure effective communication across PPS and network. Support the task force and receive guidance, develop the assessment, develop communication and engagement plan, direct development and implementation of training program and other practitioner engagement processes. |
| Leaders/champions/Task Force Co-chairs | Dr. Thomas Lawrence, Dr. Roger Barrowman | Provide leadership and cohesiveness across professional groups and provider types in network |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 7.6 - Key Stakeholders

**Instructions :**

Please identify the key stakeholders involved, both within and outside the PPS.

| Key stakeholders | Role in relation to this organizational workstream | Key deliverables / responsibilities |
|---|---|---|
| **Internal Stakeholders** | | |
| Ellis Medicine | Paul Milton, Acting CEO, AFBHC LLC Manager | Leadership staff, strategic direction support |
| Samaritan Hospital | Jim Reed, M. D., President and CEO, AFBHC LLC Manager | Leadership staff, strategic direction support |
| St. Mary's Healthcare | Vic Giulianelli, CEO, AFBHC LLC Manager | Leadership staff, strategic direction support |
| Hometown Health Centers | Joe Gambino, CEO, AFBHC LLC Manager | Leadership staff, strategic direction support |
| Whitney M. Young, Jr. Health Center | Dave Shippee, CEO, AFBHC LLC Manager | Leadership staff, strategic direction support |
| Capital Care Medical Group, P.C. | Lou Snitkof, M. D., CMO, AFBHC LLC Manager | Leadership staff, strategic direction support |
| Community Care Physicians, P.C. | Richard Scanu, COO/CFO, AFBHC LLC Manager | Leadership staff, strategic direction support |
| **External Stakeholders** | | |
| All providers in network | Provider | Achieve goals, receive incentives |
| PAC members | Advisory group | Guide the development of projects |
| Medical Society of the State of NY | Advisory and disseminate communication | Guide development of practitioner engagement |
| American Academy of Family Physicians | Advisory and disseminate communication | Guide development of practitioner engagement |
| New York State Psychiatric Association | Advisory and disseminate communication | Guide development of practitioner engagement |
| Mental Health Association in New York State | Advisory and disseminate communication | Guide development of practitioner engagement |
| American College of Physicians | Advisory and disseminate communication | Guide development of practitioner engagement |
| Adirondack Health Institute PPS | Coordination and disseminate communication | Coordination of practitioner engagement |
| Albany Medical Center PPS | Coordination and disseminate communication | Coordination of practitioner engagement |
| Leatherstocking Collaborative Health PPS | Coordination and disseminate communication | Coordination of practitioner engagement |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 7.7 - IT Expectations

**Instructions :**

Please clearly describe how the development of shared IT infrastructure across the PPS will support this particular workstream.

AFBHC will leverage the following IT tools to engage the healthcare workforce on new and existing processes, coordinate patient care, recruit staff, and provide secure communication methods across the PPS: (1) Learning Management System, (2) Electronic Newsletters, (3) AFBHC website, and (4) HIXNY. A needs assessment will be conducted to determine scope of internet-based centralized delivery system of required and optional training courses across providers within AFBHC. This needs assessment will result in a plan for development of an AFBHC-wide Learning Management System (LMS.) In addition to providing training content and modalities, AFBHC will be able to track and report on workforce training initiatives. AFBHC will utilize IT-based communication tools to engage the workforce. In addition to the LMS, electronic newsletters will be used to communicate with employees within AFBHC. The AFBHC website will also have a workforce section outlining workforce efforts being undertaken, including an employment recruitment section to direct individuals to provider organization's job opportunities within AFBHC. Finally, providers will be connected to HIXNY, the Regional Health Information Exchange (RHIO) that serves as the hub to securely collect and deliver health information in real-time between authorized providers and their authorized employees. Providing real-time data empowers the appropriate health care workforce with meaningful information and secure communication modality across systems.

### IPQR Module 7.8 - Progress Reporting

**Instructions :**

Please describe how you will measure the success of this organizational workstream.

The success of the practitioner engagement workstream will be measured by the degree that providers are engaged, metrics and milestones are being achieved, the number of providers participating in the incentive programs, the amount of incentive funds being earned by providers, Medicaid members access and satisfaction are positively reflected in their HEDIS and CAHPS measures as well as outcome measures. In addition practitioners' satisfaction with their degree of engagement is important for the adoption of projects and DSRIP transformation. Therefore, surveys of physicians determining their degree of satisfaction with engagement will be conducted at appropriate intervals.

### IPQR Module 7.9 - IA Monitoring

**Instructions :**

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Section 08 – Population Health Management

#### IPQR Module 8.1 - Prescribed Milestones

**Instructions :**

Please enter and update target dates, as well as breakdown tasks with target dates for prescribed milestones. For milestones that are due within the reporting period, documentation is required to provide evidence of milestone achievement.
Any explanations regarding altered or missed target commitments must be included within the textbox, not as narrative within uploaded documentation.

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| **Milestone #1**<br>Develop population health management roadmap. | In Progress | Population health roadmap, signed off by PPS Board, including:<br>-- The IT infrastructure required to support a population health management approach<br>-- Your overarching plans for achieving PCMH 2014 Level 3 certification in relevant provider organizations<br>--Defined priority target populations and define plans for addressing their health disparities. | 04/01/2015 | 06/30/2016 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 | NO |
| **Task**<br>1. Develop the AFBHC Population Health Management model that cares for people within a PCMH/behavioral/mental health foundation surrounded by a comprehensive integrated network inclusive of medical specialists, acute, post-acute, community based and social services. The model is inclusive of risk-stratification of populations with attendant prevention and wellness interventions with effective transitions and care coordination processes. The model is supported by robust technology, analytics, and actuarially-sound payment models from managed care organizations. | In Progress | 1. Develop the AFBHC Population Health Management model that cares for people within a PCMH/behavioral/mental health foundation surrounded by a comprehensive integrated network inclusive of medical specialists, acute, post-acute, community based and social services. The model is inclusive of risk-stratification of populations with attendant prevention and wellness interventions with effective transitions and care coordination processes. The model is supported by robust technology, analytics, and actuarially-sound payment models from managed care organizations. | 04/01/2015 | 12/31/2015 | 12/31/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 | |
| **Task**<br>2. Finalize and formally adopt the Population Health Management model | In Progress | "a. Present and discuss PHM model throughout the network to promote common shared understanding and ensure all network stakeholders move in the same strategic and operational direction | 04/01/2015 | 06/30/2016 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| | | b. Formally adopt the PHM model at the Clinical Integration and Quality Committee and Subcommittees<br>c. Formally adopt the PHM model at the Board of Managers.<br><br>" | | | | | | | |
| **Task**<br>3. Using the AFBHC PHM model risk-stratify populations within the PCMH/behavioral/mental health foundation and target populations for specific interventions including health disparities. | In Progress | 3. Using the AFBHC PHM model risk-stratify populations within the PCMH/behavioral/mental health foundation and target populations for specific interventions including health disparities. | 04/01/2015 | 06/30/2016 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 | |
| **Task**<br>4. With the assistance of the Rapid Cycle Evaluation team, identify any interventions that may not be working well and take remedial action communicating to appropriate stakeholders. | In Progress | a. The Rapid Cycle Evaluation team will produce reports with sufficient frequency to detect early patterns of performance. | 04/01/2015 | 06/30/2016 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 | |
| **Task**<br>5. Assess Population Health tools currently being used throughout the PPS (refer to IT Systems and Processes workstream plan, Milestone 1) | In Progress | 5. Assess Population Health tools currently being used throughout the PPS (refer to IT Systems and Processes workstream plan, Milestone 1) | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task**<br>6. IT Assessment and Issue Resolution Planning - Cross- PPS Partner capabilities assessment (Patient Engagement Tools, Patient Registries, Longitudinal Patient Record). | In Progress | 6. IT Assessment and Issue Resolution Planning - Cross-PPS Partner capabilities assessment (Patient Engagement Tools, Patient Registries, Longitudinal Patient Record). | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task**<br>7. Develop roadmap for population health management, including IT infrastructure, targeted populations and organizational integration (refer to IT Systems and Processes workstream plan, Milestone 1). | In Progress | 7. Develop roadmap for population health management, including IT infrastructure, targeted populations and organizational integration (refer to IT Systems and Processes workstream plan, Milestone 1). | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task**<br>8. Develop roadmap of tactical and strategic recommendations with high-level budget estimates and resource requirements. | In Progress | 8. Develop roadmap of tactical and strategic recommendations with high-level budget estimates and resource requirements. | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task**<br>"9. Establish a schedule for monitoring progress to achieving PCMH 2013 Level 3 certification<br>" | In Progress | "a. Based on analysis of pros/cons of corporate vs individual practice NCQA PCMH recognition, select approach(es) for provider groups.<br>b. Collect NCQA recognition documentation from practices | 04/01/2015 | 12/31/2015 | 12/31/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| | | who are currently 2014 or 2011 Level 3 recognized (60% of PPS PCPs).<br>d. Establish goals and timelines to achieve 2014 Level 3 NCQA recognition by the end of DY3.<br>e. Asses the practices' needs for technical assistance and provide technical assistance.<br>f. Establish a method to track and report progress on a regular basis. " | | | | | | | |
| **Task**<br>10. Where electronic functionality is not yet ready, implement alternate in the interim. Track conversion to electronic systems. | In Progress | 10. Where electronic functionality is not yet ready, implement alternate in the interim. Track conversion to electronic systems. | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task**<br>11. Review, revise and align policies, procedures and guidelines for using population tools across the PPS. | In Progress | "a. Include review process for overseeing, coordinating, and managing projects to meet measurement and reporting deadlines<br>b. Establish feedback systems to monitor effectiveness of population health tools and processes for rapid resolution of challenges<br>" | 04/01/2015 | 06/30/2016 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 | |
| **Task**<br>12. Submit IT roadmap consistent with PHM model to PPS board for approval. | In Progress | 12. Submit IT roadmap consistent with PHM model to PPS board for approval. | 04/01/2015 | 06/30/2016 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 | |
| **Milestone #2**<br>Finalize PPS-wide bed reduction plan. | In Progress | PPS Bed Reduction plan, signed off by PPS Board. This should set out your plan for bed reductions across your network, including behavioral health units/facilities, in line with planned reductions in avoidable admissions and the shift of activity from inpatient to outpatient settings. | 04/01/2015 | 06/30/2017 | 04/01/2015 | 06/30/2017 | 06/30/2017 | DY3 Q1 | NO |
| **Task**<br>"1. For facilities and facility capacities, including behavioral health units/facilities, there will be no reduction within the earlier years as area hospitals within the PPS have gone through consolidation via the Berger Commission in 2006, with many other hospitals following suit in ""right-sizing"" activities. Identifying bed utilization process and improving care pathways for inpatient admissions will be a component of | In Progress | "a. Develop plan to monitor PPS bed reduction needs at strategic intervals. Include reassessments of hospital and skilled nursing facility inpatient volumes, metrics, readmission trends after DSRIP projects implemented and functioning. Focus on outcomes for projects 2.b.iii, 2.b.iv, 2.b.viii and 3.g.i to determine if project specific metrics have impact on hospital volumes.<br>a. Track bed utilization rates on annual basis for DSRIP years 4 and 5 requirements within projected population health | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| the PPS-wide bed reduction plan. Beds may be reduced by years 4 and 5 after determined by DSRIP success. This also holds true of long term care beds. For the DSRIP implement plan, the AFBHC will monitor bed status at designated intervals.<br><br>" | | roadmap<br>b. Report findings of bed utilization reports to leadership of PPS after assessments completed<br>" | | | | | | | |
| **Task**<br>2. Bed reduction/bed utilization status signed off by PPS board. | In Progress | 2. Bed reduction/bed utilization status signed off by PPS board. | 04/01/2015 | 06/30/2017 | 04/01/2015 | 06/30/2017 | 06/30/2017 | DY3 Q1 | |

### IA Instructions / Quarterly Update

| Milestone Name | IA Instructions | Quarterly Update Description |
|---|---|---|

No Records Found

### Prescribed Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|

No Records Found

### Prescribed Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|
| Develop population health management roadmap. | Tasks 1 and 9, originally scheduled for 12/31/2015 have been moved to 06/30/16 to reflect the ongoing nature of the work. |
| Finalize PPS-wide bed reduction plan. | |

### Milestone Review Status

| Milestone # | Review Status | IA Formal Comments |
|---|---|---|
| **Milestone #1** | Pass & Ongoing | |
| **Milestone #2** | Pass & Ongoing | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 8.2 - PPS Defined Milestones

**Instructions :**

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones.

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
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### PPS Defined Milestones Narrative Text

| Milestone Name | Narrative Text |
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# New York State Department Of Health
# Delivery System Reform Incentive Payment Project

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 8.3 - Major Risks to Implementation & Risk Mitigation Strategies

**Instructions :**

Please describe the key challenges or risks that you foresee in implementing these cross-cutting organizational strategies, including potential impacts on specific projects and, crucially, any risks that will undermine your ability to achieve outcome measure targets.

Population Health IT (PHIT) systems and tools are required to fulfill communication, patient care, patient tracking, and outcomes monitoring needs across the continuum. Because PHIT is foundational to most DSRIP project requirements, delayed PHIT implementation steps delay other project steps and puts the PPS at risk of not meeting project speed and scale requirements. The mitigation strategy includes accelerating implementation of PHIT interoperability and tools and using alternate methods where EHRs and PHIT tool functionality are not yet ready.

Other risks to the successful implementation of the Population Health Strategy is user readiness and lack of knowledge of Population Health IT. Historically, health care has been focused on care of the individual; the DSRIP initiative focuses on the health of populations. This paradigm change can be difficult for some. For those practices that are not yet PCMH recognized, they are likely unfamiliar with population health IT tools. Even if the practice has been using an EMR, population health IT tools add another level of expertise in computer use. For any practices that do not yet have an EMR, they face the dual challenge of converting to EMR and implementing population health tools. To mitigate this risk, this workstream will work closely with Workforce to offer training and change management support.

There is a lag with some providers and organizations, such as behavioral health outpatient settings in regards to EMR development and meeting meaningful use and reporting requirements. A comprehensive approach to EMR use will be part of the mitigation strategy to reduce this risk. Population Health strategies will work with IT implementation strategies to assess current state and assist in moving to future state to meet the needs of the providers

### IPQR Module 8.4 - Major Dependencies on Organizational Workstreams

**Instructions :**

Please describe any interdependencies with other organizational workstreams (IT Systems and Processes, Clinical Integration, etc.)

This project ties closely with the Cultural Competency Strategy in its aim to improve the health and health care of the target populations, track outcomes according to disparities, and promote community and patient engagement.

To implement the operational components of the Population Health Management implementation requires coordination with all functional workstreams, particularly the 1) IT Systems and Processes workstream; 2) Clinical Integration workstream; 3) Performance Reporting workstream; and 4) funds flow workstream. Population health management is integral to the care management coordination and alignment efforts described in Project 2.a.i. - Integrated Delivery System. All DSRIP projects contain various types of links to Population Health Management tools and PHIT systems.

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 8.5 - Roles and Responsibilities

**Instructions :**

Please list and elaborate upon the key people/organizations responsible for this organizational work stream and describe what their responsibilities involve.

| Role | Name of person / organization (if known at this stage) | Key deliverables / responsibilities |
|---|---|---|
| AFBHC Information Technology Lead | In Progress | Implementation and Oversight of population health IT strategy |
| Population Health Management Taskforce | In Progress | Develop, coordinate, oversee and align PPS cultural competency, health literacy and community engagement strategy and training. Monitors the impacts of DSRIP projects in terms of inpatient & community capacity; monitors assessment and needs for capacity change linked to improvements in population health management. |
| AFBHC and IHANY Clinical Integration and Quality Committees | In Progress | Implement and utilize population health tools in their practices |
| AFBHC Vice President of Clinical Operations | Brenda Maynor (Interim) | Oversee, coordinate and align care management across the PPS. |
| AFBHC Vice President of Performance Operations | Tom McCarroll (Interim) | Oversee, coordinate and align PPS operations to achieve measurable improvements in population health. |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 8.6 - Key Stakeholders

**Instructions :**

Please identify the key stakeholders involved, both within and outside the PPS.

| Key stakeholders | Role in relation to this organizational workstream | Key deliverables / responsibilities |
|---|---|---|
| **Internal Stakeholders** | | |
| AFBHC PPS PMO | Oversight of DSRIP projects | Jointly responsible for Bed Reduction/Utilization Plan |
| Professional Peer Groups | Key role in the adoption of population health management practices amongst their members | Active engagement in the development of training & education materials |
| Practitioners | Use appropriate population tools in their practices | DSRIP metrics |
| Care Coordinators | Care management | For those projects requiring care management, achievement of project outcomes |
| **External Stakeholders** | | |
| HIXNY<br>9-24-15 Scott Momrow | Support connectivity | Providers are able to share patient information across the PPS |
| Public Health representatives<br>9-24-15: We will be organizing the county mental health commissioners & public health officials to meet & collaborate with the Alliance. Names pending. | Population health experience | Coordination of community activities |
| Adirondack Health Institute PPS<br>9-24-15: Cathy Homkey, CEO | Neighboring DSRIP PPS | Coordination of population health management |
| Albany Medical Center PPS<br>9-24-15: George Clifford, Evan Brooksby, & Dr. Fredrick Venditti | Neighboring DSRIP PPS | Coordination of population health management |
| Leatherstocking Collaborative Health PPS<br>9-24-15: Sue van der Sommen, Executive Director | Neighboring DSRIP PPS | Coordination of population health management |
| All New York State PPSs<br>9-24-15: Currently, the CEO is establishing a network to collaborate with other PPS's in our region. To the extent there is a learning opportunity, cross fertilization efforts will be established to strengthen each others knowledge base. | State wide DOH DSRIP PPS | Coordination of PPS transformation |
| Patients & Families | Recipient of improved services | Feedback on outcomes |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Key stakeholders | Role in relation to this organizational workstream | Key deliverables / responsibilities |
|---|---|---|
| 9-24-15: Individuals who represent patients or families will be identified as appropriate to serve on planning groups. | | |

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

## DSRIP Implementation Plan Project

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### IPQR Module 8.7 - IT Expectations

**Instructions :**

Please describe the current Population Health Management IT capabilities in place throughout your PPS network and what your plans are at this stage for leveraging these capabilities and/or developing new IT infrastructure.

IT infrastructure is an essential component of population health management. IT infrastructure will be developed to support the following population health management processes: (1) financial and clinical risk stratification; (2) care delivery and coordination; (3) patient engagement; (4) monitoring outcomes; and (5) assessing impact of intervention(s) on overall cost of care. The primary pre-requisite for enabling these processes is acquisition and aggregation of data from across the AFBHC. This task is complicated by the many IT systems that are being used across the PPS. In order to better determine the role of HIXNY and other data aggregation platforms, a comprehensive data assessment will be conducted. In parallel to the data assessment, a functionality needs assessment will be conducted at the DSRIP program level to prioritize the IT capabilities needed to support the individual programs. The data assessment and the functionality needs assessment will drive decision-making about IT infrastructure and IT planning to support population health management program initiatives.

### IPQR Module 8.8 - Progress Reporting

**Instructions :**

Please describe how you will measure the success of this organizational workstream.

The AFBHC PMO will utilize project management, population health, board management, and accounting software to manage the PPS infrastructure and projects. The project management tool will clearly define milestones, steps, and timing expectations, and be reported monthly utilizing a balanced score card approach for all committees. The balance score card approach will identify risks, performance and financial trends, and expectations by function and project to align with accountable PPS stakeholders.

### IPQR Module 8.9 - IA Monitoring

**Instructions :**

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Section 09 – Clinical Integration

#### IPQR Module 9.1 - Prescribed Milestones

**Instructions :**

Please enter and update target dates, as well as breakdown tasks with target dates for prescribed milestones. For milestones that are due within the reporting period, documentation is required to provide evidence of milestone achievement.
Any explanations regarding altered or missed target commitments must be included within the textbox, not as narrative within uploaded documentation.

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| **Milestone #1**<br>Perform a clinical integration 'needs assessment'. | In Progress | Clinical integration 'needs assessment' document, signed off by the Clinical Quality Committee, including:<br>-- Mapping the providers in the network and their requirements for clinical integration (including clinical providers, care management and other providers impacting on social determinants of health)<br>-- Identifying key data points for shared access and the key interfaces that will have an impact on clinical integration<br>-- Identify other potential mechanisms to be used for driving clinical integration | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | NO |
| **Task**<br>1: Project leads/project teams will assess and map by provider type current state of integrated care and care transitions, behavioral health access, acute care, ambulatory care, discharge and readmission processes, palliative care, different patient populations including IDD patients, home health and population health issues through the lens of their respective projects. This work will be accomplished within the framework of the AFBHC Population Health Management Model. | In Progress | 1: Project leads/project teams will assess and map by provider type current state of integrated care and care transitions, behavioral health access, acute care, ambulatory care, discharge and readmission processes, palliative care, different patient populations including IDD patients, home health and population health issues through the lens of their respective projects. This work will be accomplished within the framework of the AFBHC Population Health Management Model. | 04/01/2015 | 12/31/2015 | 12/31/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task**<br>2: The AFBHC Workforce Committee (WC) is tasked with assessing the workforce needs across all projects and all organizational sections of the Implementation Plan. The Clinical | In Progress | 2: The AFBHC Workforce Committee (WC) is tasked with assessing the workforce needs across all projects and all organizational sections of the Implementation Plan. The Clinical Integration and Quality Committee will work with the WC to review and offer input towards helping refine the | 04/01/2015 | 12/31/2015 | 12/31/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |

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| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| Integration and Quality Committee will work with the WC to review and offer input towards helping refine the workforce needs pertaining to Clinical Integration. | | workforce needs pertaining to Clinical Integration. | | | | | | | |
| **Task**<br>3. Create a robust provider matrix that outlines provider requirements (e.g., DSRIP reporting requirements, PPS reporting requirements, DSRIP project functional requirements), current clinical (e.g., existing care transition programs and care coordination, including PCMH standardization) & IT state (e.g., solutions provided to support reporting and functional requirements) and project participation | In Progress | 3. Create a robust provider matrix that outlines provider requirements (e.g., DSRIP reporting requirements, PPS reporting requirements, DSRIP project functional requirements), current clinical (e.g., existing care transition programs and care coordination, including PCMH standardization) & IT state (e.g., solutions provided to support reporting and functional requirements) and project participation | 04/01/2015 | 12/31/2015 | 12/31/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task**<br>4. Outline associated data needs based upon the robust provider matrix (e.g., psycho-social information, clinical information, and claims) and connections by PPS partner (e.g., current data collected, analysis of data provided to and integrated from HIXNY, NY Department of Health, and other sources of data about the partners (e.g., Universal Assessment Tool) to inform the recommendations and plan for clinical integration needs | In Progress | 4. Outline associated data needs based upon the robust provider matrix (e.g., psycho-social information, clinical information, and claims) and connections by PPS partner (e.g., current data collected, analysis of data provided to and integrated from HIXNY, NY Department of Health, and other sources of data about the partners (e.g., Universal Assessment Tool) to inform the recommendations and plan for clinical integration needs | 04/01/2015 | 12/31/2015 | 12/31/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task**<br>5. Draft a clinical integration needs assessment in conjunction with IT, and present to finance and clinical quality committees with recommendations and financial implications; Director of Clinical Operations, IT and Operations Director to complete assessment with input from HIXNY | In Progress | 5. Draft a clinical integration needs assessment in conjunction with IT, and present to finance and clinical quality committees with recommendations and financial implications; Director of Clinical Operations, IT and Operations Director to complete assessment with input from HIXNY | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task**<br>6. Consider any physical office changes required to promote integration of care considering technology alternatives to accomplish integration goals. | In Progress | 6. Consider any physical office changes required to promote integration of care considering technology alternatives to accomplish integration goals. | 04/01/2015 | 12/31/2015 | 12/31/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |

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| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>7. Submit final plan that to clinical quality committee for plan approval. | In Progress | 7. Submit final plan that to clinical quality committee for plan approval. | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Milestone #2**<br>Develop a Clinical Integration strategy. | In Progress | Clinical Integration Strategy, signed off by Clinical Quality Committee, including:<br>-- Clinical and other info for sharing<br>-- Data sharing systems and interoperability<br>-- A specific Care Transitions Strategy, including: hospital admission and discharge coordination; and care transitions and coordination and communication among primary care, mental health and substance use providers<br>-- Training for providers across settings (inc. ED, inpatient, outpatient) regarding clinical integration, tools and communication for coordination<br>-- Training for operations staff on care coordination and communication tools | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | NO |
| **Task**<br>1: Develop, appoint, and convene on a recurring schedule a Clinical Integration team that incorporates Clinical Quality, IT and key clinical project leads to monitor, evaluate and measure progress, risks and strategies toward milestones | Completed | 1: Develop, appoint, and convene on a recurring schedule a Clinical Integration team that incorporates Clinical Quality, IT and key clinical project leads to monitor, evaluate and measure progress, risks and strategies toward milestones | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task**<br>2. Utilize feedback from committees and board to develop a draft strategic plan, including the path towards a longitudinal patient record that incorporates clinical, claims, and psycho-social information for PPS partners use and systems for PPS partners to use them, specific strategies around Care Transitions and care coordination among primary care, mental health, IDD population and substance use providers and the path towards achieving it related to training, tools, communication, and the path towards managing sufficient compliance/member consent for sharing the data | In Progress | 2. Utilize feedback from committees and board to develop a draft strategic plan, including the path towards a longitudinal patient record that incorporates clinical, claims, and psycho-social information for PPS partners use and systems for PPS partners to use them, specific strategies around Care Transitions and care coordination among primary care, mental health, IDD population and substance use providers and the path towards achieving it related to training, tools, communication, and the path towards managing sufficient compliance/member consent for sharing the data | 04/01/2015 | 12/31/2015 | 12/31/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task**<br>3. Present the Clinical Integration Strategy to the | In Progress | 3. Present the Clinical Integration Strategy to the Clinical Integration and IT committees, including structural and IT | 04/01/2015 | 12/31/2015 | 12/31/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |

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| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| Clinical Integration and IT committees, including structural and IT changes when necessary for ease of client and provider use for warm hand offs. | | changes when necessary for ease of client and provider use for warm hand offs. | | | | | | | |
| **Task**<br>4. Submit for board approval of Clinical Integration Strategy. | In Progress | 4. Submit for board approval of Clinical Integration Strategy. | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |

### IA Instructions / Quarterly Update

| Milestone Name | IA Instructions | Quarterly Update Description |
|---|---|---|

No Records Found

### Prescribed Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|

No Records Found

### Prescribed Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|
| Perform a clinical integration 'needs assessment'. | Tasks 1-4, and T6, originally scheduled for 12/31/2015 have been moved to 3/31/16 to reflect the ongoing nature of the work. |
| Develop a Clinical Integration strategy. | Tasks 2 and 3, originally scheduled for 12/31/2015 have been moved to 3/31/2016 to reflect the ongoing nature of the work. |

### Milestone Review Status

| Milestone # | Review Status | IA Formal Comments |
|---|---|---|
| **Milestone #1** | Pass & Ongoing | |
| **Milestone #2** | Pass & Ongoing | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 9.2 - PPS Defined Milestones

**Instructions :**

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones.

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|

No Records Found

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 9.3 - Major Risks to Implementation & Risk Mitigation Strategies

**Instructions :**

Please describe the key challenges or risks that you foresee in improving the level of clinical integration throughout your network and achieving the milestones described above. Describe potential impacts on specific projects and any risks that will undermine your ability to achieve outcome measure targets.

The implementation of the clinical integration work stream takes into account the specific clinical projects and the work streams of practitioner engagement, workforce, cultural competency and all operational components of the DSRIP project. This complexity presents a risk to the successful improvement of clinical integration. To mitigate this risk, the AFBHC PPS will establish a robust Project Management Office (PMO) to oversee the clinical integration, coupled with IT work stream to assess current state, the transition to transformation of care within the provider groups, and the infusion of project requirements based on gaps identified during current state assessment. Practitioner engagement, workforce and governance will need to support the clinical transformation throughout the process change. Leads from the clinical integration work stream will need to develop dashboards, timelines and make decisions based on transformation of care. The workforce may need to be retrained, redeployed and reassigned dependent on community needs and the transition from acute care to health transformation. The Clinical Integration Quality component of this work stream will ensure quarterly metrics are tracked, work with IT and other work streams to report deficiencies, gaps, risks and mitigation strategies as they arise to ensure transition.

Another risk would be the timeline and rapid speed and scale of implementation of projects and plans. The AFBHC PPS has established a Steering Committee for planning and initiating the projects, established a PMO division, and will partner with IHANY and other established organizations to fulfill its obligations to the DSRIP timeline. Quality metrics will be shared with its members, RCA will be addressed to mitigate issues and determine process to improve integration in a timely manner and dashboards and data will be shared and used to demonstrate progress.

IT Risks: Data Interoperability dependent upon working with multiple vendors that may not support existing standards; risk mitigation strategy is to engage vendors early and determine supplemental solutions where available.

### IPQR Module 9.4 - Major Dependencies on Organizational Workstreams

**Instructions :**

Please describe any interdependencies with other organizational workstreams (IT Systems and Processes, Clinical Integration, etc.)

The Clinical Integration work stream is dependent on the workflow and work product of Workforce, Population Health Management, Performance Improvement and Practitioner engagement. Since all projects of the DSRIP program touch on the clinical aspect of transforming health, clinical integration can be considered the "seating chart" for the symphonic integration of the work streams. IT components may connect and drive metrics, dashboards and reports, but the clinical integration has to be placed in such a way that it touches the other work streams, and plays out harmoniously when workforce, engagement, process improvement and population health are transformed.

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# Delivery System Reform Incentive Payment Project

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## Alliance for Better Health Care, LLC (PPS ID:3)

| |
|---|
| IT Systems and Processes: Completion of the milestones titled "Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network", "Develop a data security and confidentiality plan", and "Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s). |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 9.5 - Roles and Responsibilities

**Instructions :**

Please list and elaborate upon the key people/organizations responsible for this organizational workstream and describe what their responsibilities involve.

| Role | Name of person / organization (if known at this stage) | Key deliverables / responsibilities |
|---|---|---|
| Clinical Integration and Quality Committee | In Progress | Provide guidance and sign off on clinical integration needs assessment and strategy. Adoption of evidence based practices and protocols consistent across all projects and intended to be used uniformly by specific provider types across the network. |
| Project Steering Committees | In Progress | Contribute to overall Clinical Integration Strategy for three project clusters: at-risk populations, behavioral health & primary care integration, and Integrated Delivery System & Project 11 |
| Initial Project Leads from Partner Entities | Joe Twardy, Pamela Rehak, Scott Friedlander, Brenda Maynor, Erin Simao, Dave Shippee, Patrick Carrese, Keith Brown, Kathy Ristau, Kevin Jobin-Davis, Rachel Handler, Millie Ferriter, Kathy Alonge-Coons, Amanda Mulhern | Shepherd projects through early phases of planning, development, and implementation |
| AFBHC Project lead for 2.b.iii, 2.b.iv, 3.g.i | Scott Friedlander (Interim) | Implement AFBHC projects throught the central AFBHC Clinical Operations office in close collaboration with partner entities |
| AFBHC Project lead for 2.d.i | Erin Simao (Interim) | Implement AFBHC projects throught the central AFBHC Clinical Operations office in close collaboration with partner entities |
| AFBHC Project Leads for 2.a.i, 2.b.viii, 3.a.i, 3.a.iv, 3.d.ii, 4.a.iii, 4.b.i | In Progress | Implement AFBHC projects throught the central AFBHC Clinical Operations office in close collaboration with partner entities |
| VP of Performance Operations | Tom McCarroll (Interim)/AFBHC Performance Office | Provide guidance and oversight for the Performance Operations of AFBHC |
| VP of Clinical Operations | Brenda Maynor (Interim)/AFBHC Clinical Office | Provide guidance and oversight for the Clinical Operations of AFBHC |
| Operational IT & Data Committee Leads | In Progress | Provide IT support to the clinical integration process |
| Operational PCP Representative | John Collins, MD | Act as the liaison between primary care and the clinical integration process |
| Physician Representative | Thomas Lawrence, MD | Act as the liaison between physicians and the clinical integration process |
| Social/Community Worker Representative | In Progress | Act as the liaison between the community and the clinical integration process |
| Behavioral Health Representative | In Progress | Act as the liaison between behavioral health and the clinical integration process |
| Nursing Representative (care coordinators) | In Progress | Act as the liaison between care coordinators and the clinical integration process |

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| Role | Name of person / organization (if known at this stage) | Key deliverables / responsibilities |
|---|---|---|
| MCO Liaison | In Progress | Act as the liaison between MCOs and the clinical integration process |
| PCMH project lead | In Progress | Act as liasion for PCMH certification and level of acheivement to meet DSRIP needs |
| Financial VBP representatives | Dan Rinaldi and John Gahan | Act as liasion for managed care to align future payments |
| PCP Office Staff representatives | Christine Shwajlyk | Act of liaison for provider office administration |
| Nursing Representative | In Progress | Act as the liaison between nursing and the clinical integration process |

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# Delivery System Reform Incentive Payment Project

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 9.6 - Key Stakeholders

**Instructions :**

Please identify the key stakeholders involved, both within and outside the PPS.

| Key stakeholders | Role in relation to this organizational workstream | Key deliverables / responsibilities |
|---|---|---|
| **Internal Stakeholders** | | |
| Board of Managers | Leadership | "Approve Clinical Integration strategy" |
| Practitioners | Support of DSRIP Project Implementation, including new pathways, lines of accountability, responsibility and communication | Engage in the process |
| Clinical staff | Support of DSRIP Project Implementation, including new pathways, lines of accountability, responsibility and communication | Engage in the process |
| **External Stakeholders** | | |
| Patients | Care improved upon by the clinical integration of the PPS | Response to consultation on clinical integration strategy |
| Families | Communication with practitioners, particularly on behalf of children, the elderly, or those without mental capacity | Response to consultation on clinical integration strategy |
| CBOs | Supporting the development and implementation of the clinical integration strategy | Response to consultation on clinical integration strategy |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 9.7 - IT Expectations

**Instructions :**

Please clearly describe how the development of shared IT infrastructure across the PPS will support this particular workstream.

IT workstreams will build the foundation for this workstream; the clinical integration will be developed and maintained simultaneously with the IT systems process. Specifically the delivery of a longitudinal patient record that incorporates clinical, claims, and psycho-social information for PPS partners use and systems for PPS partners to use them will be a critical dependency.

### IPQR Module 9.8 - Progress Reporting

**Instructions :**

Please describe how you will measure the success of this organizational workstream.

The AFBHC PMO will utilize project management, population health, board management, and accounting software to manage the PPS infrastructure and projects. The project management tool will clearly define milestones, steps, and timing expectations, and be reported monthly utilizing a balanced score card approach for all committees. The balance score card approach will identify risks, performance and financial trends, and expectations by function and project to align with accountable PPS stakeholders. For Clinical Integration, the balance score card will track metrics related to IT Systems and Processes, but also performance of key clinical processes, such as Care Transitions and patient engagement. Within the implementation period, the AFBHC PMO will track and report on progress related to achieving data interoperability and implementing a uniform care transitions program. To assist the AFBHC, reporting will be done on two levels: the overall PPS and the individual PPS member to promote compliance. The individual PPS members will share information through their own current communication processes. External stakeholders will have appropriate access to the progress reporting as well.

### IPQR Module 9.9 - IA Monitoring:

**Instructions :**

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

## Section 10 – General Project Reporting

### IPQR Module 10.1 - Overall approach to implementation

**Instructions :**

Please summarize your intended approach to the implementation of your chosen DSRIP projects, including considerations around how this approach will allow for the successful development of concurrently implementing DSRIP projects.

The Alliance for Better Health Care (AFBHC) is committed to a coordinated, synergistic approach to meeting 100% of project requirements to transform the health care delivery system for its population. Its approach to implementation is based on the AFBHC Population Health Management Model that cares for people in a PCMH/behavioral/mental health foundation surrounded by a comprehensive integrated network inclusive of medical specialists, acute, post-acute, community based & social services. The model includes risk-stratification of populations with prevention & wellness interventions & effective transitions &care coordination processes. This is supported by robust technology, analytics, & actuarially-sound payment models.

Implementing the projects follows the accountabilities laid out in the AFBHC governance structure. The AFBHC Clinical Integration & Quality Committee will develop the foundation for the AFBHC Population Health Management Model & will align operating standards, best-practice clinical guidelines, & care pathways. The Steering Committee was instrumental in the development of the project plans & members have become leaders in the development of the plans along with staff, new volunteers, practitioners, & other stakeholders. They will continue to provide operational support through the actual implementation of the projects.

The AFBHC is established with administrative leadership & functions. The administrative functions are to establish the PPS operational structure, manage & oversee the projects implementation. The Project Management Office (PMO) reports to the AFBHC CEO & is responsible for building the processes & structures for coordination & alignment across project teams. The PMO includes clinical operations staffed with project leads for the duration. The PMO will implement & maintain the project management system to ensure milestones & metrics deadlines are met; coordinate projects with each other, other work streams & initiatives; identify & facilitate cross-team, collaborative planning (short term, ad hoc, long term) to promote alignment, provide user input, & eliminate duplication; sequence & stagger implementation according to project requirements, timeline & PPS capacities & capabilities; use feedback systems to monitor effectiveness of new tools & processes for rapid resolution of gaps or barriers; & engage leadership to resolve system barriers.

The PMO is responsible for linking project teams with the Workforce Work streams to: coordinate hiring, redeployment & training needs across projects; prepare workforce for project implementation; & ramp up staff numbers & ensure staff preparation for project implementation. Teams will follow a project process which includes: select & engage PPS project partners; define team roles & responsibilities; follow project requirements, milestones & metrics; assess partner capabilities & identify new partners to fill gaps; identify partners' current strengths; use evidence-based clinical, organizational &population health practices; use a holistic approach to services; &coordinate with other DSRIP project teams & work streams.

The PPS has identified specific roles that each provider type will play in executing project requirements. Each project has identified the role that each of the committed providers & community based organizations will play in accomplishing 100% of the project goals. Not all committed providers will be responsible for 100% of the project requirements, but rather, 100% of the project requirements will be met by the committed providers playing their respective roles in each project. For example, in the withdrawal management project (3aiv) not all PCP's that are committed to the project will seek approval for outpatient medication management, but 100% of those PCPs will be educated & linked to those that will be working in the detox centers.

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# Delivery System Reform Incentive Payment Project

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 10.2 - Major dependencies between work streams and coordination of projects

**Instructions :**

Please describe how your approach will handle interdependencies between complementary projects, as well as between projects and cross-cutting PPS initiatives - for example, an IT infrastructure upgrade, or the establishment of data sharing protocols.

The AFBHC has integrated planning for like projects to leverage synergies, incorporate dependencies, minimize unnecessary duplication, promote efficiency and leverage limited time of participants. Planning and implementation for Projects 2.a.i. and 2.d.i are grouped as the Integrated Delivery System projects; 2.b.iii., 2.b.iv., 2.b.viii, 3.d.ii, 3.g.i, and 4.b.i are grouped as the At-Risk Populations projects; 3.a.i., 3.a.iv., and 4.a.iii. are grouped as the Behavioral Health and Primary Care integration projects. The project team chairs lead their respective project teams and work together to coordinate the projects within their group.

Based on project selection, projects and work streams are naturally synergistic. The cultural competency and health literacy work stream provides support for the standard for culturally and linguistically appropriate services for the PPS projects, including PCMH; care management services and patient registries within the population health work stream provide the model, policies and procedures and tools to meet the care management, outreach and transitions of care requirements for the PCMH; behavioral health and primary care integration serve both primary care and the behavioral health projects.

The PMO is also responsible for providing and coordinating technical support for the project teams including: 1) team facilitation support and improvement tools; 2) data and analytic support; and 3) criteria and standards for dashboards and project evaluation. The PMO is responsible for linking project teams with the IT work stream (refer to Part 1 IT Systems and Processes work streams) to provide user input, establish timelines, and to facilitate transitional manual processes until electronic systems are functional.

The Patient Centered Medical Home provides the platform for implementing the role of primary care providers in the projects. The AFBHC will leverage the overlapping requirements of the DSRIP projects and the NCQA PCMH requirements. The integrated role of the PCP is managed through the combined efforts of the AFBHC Clinical Integration and Quality Committee and the IHANY (ACO) Clinical Integration and Quality Committee to ensure alignment and reduce duplication.

Select PPS functions supporting DSRIP project implementation will be housed in the PMO: communication planning; care management alignment, integration, and oversight; staff development and patient/family education; population health analytics, decision-support, reporting and outreach tools; and culturally competence / health literacy / community engagement assessment development, alignment, and oversight. The PPS will coordinate and align with other projects : coordinates DSRIP projects with each other, other work streams and initiatives; facilitates cross-team, collaborative planning and alignment; sequences and staggers implementation according to project requirements, PPS capabilities, and care site capacities; uses feedback systems to monitor effectiveness and activate rapid response process; and engages PPS leaders to resolve barriers.

In addition to their role in the overall operations of the AFBHC, the Cultural Competency / Health Literacy, IT systems, Population Management, and Workforce workstreams (explained in more detail in the workstream sections of the implementation plan) all have linkages to the projects and will work closely with the Project Managers and Project teams to facilitate the respective infrastructures are in place for successful project implementation according to defined timelines.

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 10.3 - Project Roles and Responsibilities

**Instructions :**

Please outline the key individuals & organizations that play a role in the delivery of your PPS's DSRIP projects, as well as what their responsibilities are regarding governance, implementation, monitoring and reporting on your DSRIP projects.

| Role | Name of person / organization (if known at this stage) | Key deliverables / responsibilities |
|---|---|---|
| Oversight | Board of Managers | Governance |
| Providers | Ellis Medicine | Implement project requirements as indicated |
| Providers | St Peter's Health Partners | Implement project requirements as indicated |
| Providers | St. Mary's Healthcare Amsterdam | Implement project requirements as indicated |
| Providers | Whitney M Young Jr Health Center | Implement project requirements as indicated |
| Providers | Hometown Health | Implement project requirements as indicated |
| Providers | Community Care Physicians | Implement project requirements as indicated |
| Providers | Capital Care Medical Group | Implement project requirements as indicated |
| The Innovative Health Alliance of New York LLC (IHANY) is an Accountable Care Organization (ACO) participating in the Medicare Shared Savings Program (MSSP). IHANY has the same service area and many of the same partners and providers as AFBHC, so the two entities expect to share appropriate functions to maximize efficiency and effectiveness. | IHANY | Collaborators for clinical integration and EBM |
| Initial Project Leads from Partner Entities | Joe Twardy, Pamela Rehak, Scott Friedlander, Brenda Maynor, Erin Simao, Dave Shippee, Patrick Carrese, Keith Brown, Kathy Ristau, Kevin Jobin-Davis, Rachel Handler, Millie Ferriter, Kathy Alonge-Coons, Amanda Mulhern | Sheperd projects through early phases of planning, development, and implementation |
| AFBHC Project lead for 2.b.iii, 2.b.iv, 3.g.i | Scott Friedlander (Interim) | Implement AFBHC projects throught the central AFBHC Clinical Operations office in close collaboration with partner entities |
| AFBHC Project lead for 2.d.i | Erin Simao (Interim) | Implement AFBHC projects throught the central AFBHC Clinical Operations office in close collaboration with partner entities |
| AFBHC Project Leads for 2.a.i, 2.b.viii, 3.a.i, 3.a.iv, 3.d.ii, 4.a.iii, 4.b.i | In Progress | Implement AFBHC projects throught the central AFBHC Clinical Operations office in close collaboration with partner entities |
| VP of Performance Operations | Tom McCarroll (Interim)/AFBHC Performance Office | Provide guidance and oversight for the Performance Operations of AFBHC |
| VP of Clinical Operations | Brenda Maynor (Interim)/AFBHC Clinical Office | Provide guidance and oversight for the Clinical Operations of AFBHC |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

# New York State Department Of Health
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## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 10.4 - Overview of key stakeholders and how influenced by your DSRIP projects

**Instructions :**

In the below table, please set out who the key stakeholders are that play a major role across multiple DSRIP projects. Please give an indication of the role they play and how they impact your approach to delivering your DSRIP projects.

| Key stakeholders | Role in relation to this organizational workstream | Key deliverables / responsibilities |
|---|---|---|
| **Internal Stakeholders** | | |
| Board of Managers | Leadership of AFBHC | "Oversight of strategic direction, performance and achievement per Implementation Plan. Oversight of PPS Chief Executive Officer, strategic direction, Implementation Plan execution including milestones and metrics, short and long-term financial performance and health of the PPS and key providers, staffing, workforce development and engagement. Development of Operating Agreement, policies, provider agreements, fund distributions. " |
| Compliance Officer and Audit and Compliance Committee members | Ensure Compliance | Compliance with federal and state laws and other regulations. Ensuring privacy protection and development and oversight of related policies. |
| Finance Committee | Oversee finances | Oversee the financial sustainability and health of the AFBHC and practitioners ensuring the short and long term viability of the organization. |
| IT & Data Committee | Oversee technology | Technology support, making population health and clinical communication possible. Oversee the development and implementation of technology plan to ensure the support for clinical workflows and timely and safe exchange of patient information. |
| Clinical Integration and Quality Committee | Oversee clinical integration | Adoption of evidence based practices and protocols consistent across all projects and intended to be used uniformly by specific provider types across the network. |
| Workforce Committee | Oversee workforce | Responsible for the AFBHC overall workforce strategy. Oversees the Workforce Implementation Plan and the approval of required Milestones within the plan. Responsible for overseeing the collection of data required for workforce quarterly reporting. Coordinates workforce activities with Project Leads. |
| Practitioner Engagement Taskforce | Spearhead practitioner engagement | Be ambassadors for engagement. Guide the assessment, development of communication and engagement plan, training program development, and other practitioner engagement processes. |

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| Key stakeholders | Role in relation to this organizational workstream | Key deliverables / responsibilities |
|---|---|---|
| Cultural Competency Taskforce | Spearhead cultural competency initiatives | Develop, coordinate, oversee and align PPS cultural competency, health literacy and community engagement strategy and training |
| Project Steering Committees | Oversee Projects | Provide strategic direction for three project clusters: at-risk populations, behavioral health & primary care integration, and Integrated Delivery System & Project 11 |
| **External Stakeholders** | | |
| HIXNY | IT Connection | IT system connectivity partner |
| Hope House, Inc. | Recovery program | Residential recovery program |
| Belvedere Health Services | Home Care | Home care services |
| Schenectady County Office of Community Services | Government Office | Ensure comprehensive array of services across disability groups |
| Healthy Capital District Initiative (Contact: Kevin Jobin-Davis) | Care access coordinators | Facilitate health care access |
| Albany County Department of Mental Health (Contact: Stephen Giordano PhD.) | Behavioral Health | Local Government Unit; and provider of outpatient treatment services for persons with Mental Illness and Substance Abuse |
| Community Health Center Homecare | Home Care | in-home healthcare services |
| Rensselaer County Department of Mental Health (Contact: Katherine G. Alonge-Coons LCSWR) | Behavioral Health | Local government unit and safety net provider of mental hygiene services: Medicaid Service Coordination, Outpatient MH services for children, adolescents, adults and Forensic– including satellites in primary care practices; Health Home Care Coordination; community outreach for MICA population. |
| Catholic Charities of Albany (Contact: Keith Brown) | Assist in project 3.a.iv, etc. | expertise in SUD and ambulatory detox |
| Mohawk Opportunities | CBO | NFP helping individuals living with mental illness, HIV/AIDS/homeless achieve stable community living |
| Asthma Coalition of the Capital Region | Assist in project 3.d.ii | Convene stakeholders working to decrease asthma mortality and morbidity in low income areas |
| Community Hospice (Contact: Laurie Mante) | CBO | community hospice services |
| Equinox Inc. | Assist in project 3.a.iv, etc. | SUD treatment services |
| Rensselaer County Department of Health (Contact: Mary Fran Wachunas) | Government Office | Model for population health programming |
| Unity House of Troy (Contact: Christopher Burke) | CBO | Provides a full array of housing for adults with mental illness; provides services to assist those who are living in poverty, adults living with HIV/AIDS, victims of domestic violence, and children with developmental delays |
| NYS Office of Mental Health Hudson River Field Office (Contact: May Lum) | Behavioral Health | Regulatory oversight of MH continuum of care in some counties of the PPS. Standards of care for behavioral health inpatient and outpatient programs, emergency, community support, residential |

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| Key stakeholders | Role in relation to this organizational workstream | Key deliverables / responsibilities |
|---|---|---|
| | | and family care programming |
| NYS Office of Alcoholism and Substance Abuse Services (Contact: Tim Donovan) | Assist in project 3.a.iv, etc. | Regulatory oversight for the Substance Abuse continuum of care |
| Fulton County Department of Public Health | Government Office | Provide resources for projects touching Fulton County residents |
| Montgomery County Department of Public Health | Government Office | Provide resources for projects touching Montgomery County residents |
| Northern Rivers Family Services | CBO | business and managerial support to its affiliate agencies, Northeast Parent & Child Society and Parsons Child and Family Center. |
| Senior Hope Counseling | CBO | non-intensive outpatient mental health services for the elderly |
| Schenectady Community Action Program | CBO | helping persons in poverty achieve self-sufficiency |
| U.S. Committee for Refugees | CBO | protect the rights and address the needs of persons in forced or voluntary migration worldwide by advancing fair and humane public policy, facilitating and providing direct professional services, and promoting the full participation of migrants in community life. |
| Trinity Alliance | CBO | provide services to the community that will support and promote healthy families, adults and children |
| University of Albany | Education | prepares graduate level social workers to work in primary care settings managing chronic disease |
| Hudson-Mohawk Recovery Center (Contact: Tom Bendon) | Assist in project 3.a.iv, etc. | operates five NYS Office of Alcoholism and Substance Abuse Services licensed treatment facilities for addiction throughout Rensselaer County, New York |
| Conifer Park | Assist in project 3.a.iv, etc. | treatment for chemical dependency |
| Albany College of Pharmacy | Education | places residents under faculty members for training in primary care settings to maximize patient engagement and medication adherence |
| Empire State College | Education | educates and prepares nurses for practice |
| Schenectady Community College | Education | educates and prepares community navigators, cultural competency and health literacy courses |
| IHANY | ACO | collaborate on clinical integration and EBM |
| Schenectady Bridges Out of Poverty | CBO | training |

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### IPQR Module 10.5 - IT Requirements

**Instructions :**

Information technology will play a crucial role in the development of an effective, integrated performing provider system. It is likely that most projects will require some level of supporting IT infrastructure. Please describe the key elements of IT infrastructure development that will play a role in multiple projects.

The IT committee reporting to the governing body provides oversight for the overall IT vision of providing the right information to the right person at the right time and in the right place. The AFBHC IT committee and it's representatives are responsible for implementing the IT operational plan that will establish connectivity, communication, and data sharing throughout the PPS. The IT Workstream team is designing the operational work plan that will: establish priorities, align disparate systems; facilitate information sharing across organizations; meet PCMH meaningful use requirements; and align IT capacity with the needs of population health management tools (refer to the IT Systems and Processes Workstream and the Population Health workstream). IT infrastructure development to support the successful implementation of DSRIP projects includes: 1) establishing processes and structures to implement the DSRIP Data-Sharing and Confidentiality requirements; 2) incorporating developing /acquiring the capabilities and infrastructure into the Population Health IT work plan to meet reporting requirements and support evidence-based practices; 3) prioritizing the steps/actions, hardware, and other resources required to achieve transition medical records and access the HIE; 4) facilitating communication between PPS IT Committee and project teams to align IT and clinical workflows; 5) putting into place population health management analytic capabilities including, but not limited to: outcomes measurement; performance dashboards; quality improvement; patient risk stratification; service utilization; complex care management; patient outreach; and care transitions (refer to Population Health workstream); 6) establishing EHR registries targeted for specific patient populations with capabilities to support reporting to monitor and track adherence with standards of care, and identify care gaps; 7) identifying alternate methods where EHR/RHIO functionality is not ready and transitioning to electronic as it becomes available.

### IPQR Module 10.6 - Performance Monitoring

**Instructions :**

Please explain how your DSRIP projects will fit into your development of a quality performance reporting system and culture.

The DSRIP projects provide the vehicle to establish PPS-wide expectations, metrics and reporting structure to inform provider and partner incentives for clinical and population performance. The AFBHC's PMO will oversee data acquisition and analytics. The PMO provides data analysis and dashboard development support to the DSRIP project teams and for ongoing DSRIP operations after the projects are fully implemented. The PMO will work closely with the partner Information Technology leaders PPS to confirm the metrics required for each project and to align metric requirements with IT capabilities. This PPS function will build upon and coordinate with existing resources in the PPS partner organizations to align tools and methods.
The PMO will work with the Population Health Management team, Performance Reporting workstreams, and the Project Managers to assess the capabilities throughout the PPS for reporting the specific metrics required by the DSRIP project; develop and acquire capabilities and infrastructure to meet project reporting requirements. The Project Managers will work with the PMO and the Project Teams to: establish the reporting plan to gather data, ensure data integrity, create and distribute project dashboards and other reports; establish the process to review, evaluate, prioritize and initiate the rapid improvement process to address gaps, determine data needs to inform project planning and assist teams with aggregating,

analyzing and interpreting data. The PPS Workforce workstream will assist in providing education and training to project teams and as needed about data analysis, management, reporting and interpretation.

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### IPQR Module 10.7 - Community Engagement

**Instructions :**

Please describe your PPS's planned approach for driving community involvement in the DSRIP projects, how you will contract with CBOs for these projects, how community engagement will contribute to the success of the projects, and any risks associated with this.

The AFBHC plan for community engagement recognizes that engagement occurs at multiple levels including policy, PPS, organizational, programmatic, and individual. This plan, as well as the PPS selection of Project 2.d.i., reflects the understanding of these levels and the interactions between them.
Representatives from community based agencies and stakeholders comprise the AFBHC PAC. Town hall meetings, website and email correspondence provide the opportunity for two-way communication between the AFBHC PPS and PAC members to provide input to project direction, invite project team participation, and generate support for project implementation. Patient scenarios are being used to describe how services will change with DSRIP implementation for populations in need. An AFBHC DSRIP newsletter has been distributed and will continue as a means of updating the community on PPS progress. The AFBHC PPS will build upon past successes in community involvement. For example, a community coalition consisting of over 70 organizations was established for the UMatter Schenectady initiative and plans to reunite and repurpose the coalition for the PPS support are underway. Established relationships with Bridges out of Poverty allow the PPS to benefit from their expertise and help teach providers, care givers and other staff to understand the burden of poverty as part of the PPS cultural competency plan. The Healthy Capital District Initiative (HCDI) R5 project brings together a wide range of physicians, community-based service providers, payers, businesses, and hospitals from the Capital District to identify interventions that will reduce use of emergency services for primary care treatable conditions. To achieve this goal, the project will determine the root causes of sub-optimal emergency room utilization, where health system gaps exist, best practice models in the region/country, and develop initiatives to improve utilization.

The PPS will leverage existing groups, such as neighborhood associations were they exist. Plans for community advisor groups that represent geographic communities and population-specific advisory groups for marginalized groups LGBTQ, people with disabilities, Veterans, formerly incarcerated individuals, etc. are underway. Community Health Workers who reflect the characteristics of the community they serve are an important component of the engagement strategy.

Responsibilities for community engagement will be housed in the DSRIP office to leverage planning, alignment, implementation and oversight across the PPS geographic region. The community engagement work stream will: 1) inventory current patient/advisory activities from PPS partners across the system; 2) identify key success factors, best practices, and effective tools; 3) define a structure and process used for community engagement, such as organizational or agency councils; project team advisors; program advisors; office practice advisors; committee advisors; 1:1 advisors, as in the peer to peer programs; 4) using the AHRQ Working with Patients and Families as Advisors: Implementation Handbook adopt and adapt these guidelines as needed to meet the needs of the characteristics of PPS population defined in the Community Needs Assessment; 5) develop expectations and provide training for patient engagement at the front line provider and care giver level: 6) establish processes to promote alignment and coordinate across site; provide flexibility for sites to adapt as needed based on the setting, beneficiary population and purpose; 7) Include engagement metrics on project dashboards (ex. Participating advisors; and, 8) coordinate with the Cultural Competency and Health Literacy Work stream plans.

Community Based Agencies are key to the success of transforming health care in the AFBHC. The PPS governing body will approve contractual

guidelines and the AFBHC CEO will be responsible for making contractual arrangements with participating CBOs.

### IPQR Module 10.8 - IA Monitoring

**Instructions :**

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## Alliance for Better Health Care, LLC (PPS ID:3)

### Section 11 – Workforce

#### IPQR Module 11.1 - Workforce Strategy Spending

**Instructions :**

Please include details on expected workforce spending on semi-annual basis. Total annual amounts must align with commitments in PPS application.

| Funding Type | Year/Quarter | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | DY1(Q1/Q2)($) | DY1(Q3/Q4)($) | DY2(Q1/Q2)($) | DY2(Q3/Q4)($) | DY3(Q1/Q2)($) | DY3(Q3/Q4)($) | DY4(Q1/Q2)($) | DY4(Q3/Q4)($) | DY5(Q1/Q2)($) | DY5(Q3/Q4)($) | Total Spending($) |
| Retraining | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Redeployment | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Recruitment | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

**Current File Uploads**

| User ID | File Type | File Name | File Description | Upload Date |
|---|---|---|---|---|

No Records Found

**Narrative Text :**

For PPS to provide additional context regarding progress and/or updates to IA.

# New York State Department Of Health
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### IPQR Module 11.2 - Prescribed Milestones

**Instructions :**

Please enter and update target dates, as well as breakdown tasks with target dates for prescribed milestones. For milestones that are due within the reporting period, documentation is required to provide evidence of milestone achievement. Any explanations regarding altered or missed target commitments must be included within the textbox, not as narrative within uploaded documentation. Please note some milestones include minimum expected completion dates.

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| **Milestone #1** Define target workforce state (in line with DSRIP program's goals). | In Progress | Finalized PPS target workforce state, signed off by PPS workforce governance body. | 09/30/2015 | 03/31/2016 | 09/30/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | NO |
| **Task** 1. Establish the AFBHC Workforce Committee (WC) which will be responsible for managing the workforce related Milestones and Action Steps in the Implementation Plan. | Completed | 1. Establish the AFBHC Workforce Committee (WC) which will be responsible for managing the workforce related Milestones and Action Steps in the Implementation Plan. | 09/30/2015 | 09/30/2015 | 09/30/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Task** 2. The WC will review and assess workforce commitments made in the PPS's Organizational and Project applications in relation to defining the target workforce state. | Completed | 2. The WC will review and assess workforce commitments made in the PPS's Organizational and Project applications in relation to defining the target workforce state. | 09/30/2015 | 09/30/2015 | 09/30/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Task** 3. The WC will assess and determine the job roles that will be impacted by each project. | In Progress | 3. The WC will assess and determine the job roles that will be impacted by each project. | 09/30/2015 | 03/31/2016 | 09/30/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task** 4. The WC will match the anticipated job role impacts with the provider organizations within the PPS. | In Progress | 4. The WC will match the anticipated job role impacts with the provider organizations within the PPS. | 09/30/2015 | 03/31/2016 | 09/30/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task** 5. The WC will utilize data collected to help define a preliminary target workforce state. | In Progress | 5. The WC will utilize data collected to help define a preliminary target workforce state. | 09/30/2015 | 03/31/2016 | 09/30/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task** 6. The WC shall utilize the Project Advisory Committee (PAC) to provide input to the preliminary target workforce state. | In Progress | 6. The WC shall utilize the Project Advisory Committee (PAC) to provide input to the preliminary target workforce state. | 09/30/2015 | 03/31/2016 | 09/30/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task** 7. The WC shall consider PAC suggestions and recommendations into further defining the target | In Progress | 7. The WC shall consider PAC suggestions and recommendations into further defining the target workforce state. | 09/30/2015 | 03/31/2016 | 09/30/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |

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| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| workforce state. | | | | | | | | | |
| **Task**<br>8. Using the data and information gathered, the WC will define the target workforce state and present to the Board of Managers for approval. | In Progress | 8. Using the data and information gathered, the WC will define the target workforce state and present to the Board of Managers for approval. | 09/30/2015 | 03/31/2016 | 09/30/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Milestone #2**<br>Create a workforce transition roadmap for achieving defined target workforce state. | In Progress | Completed workforce transition roadmap, signed off by PPS workforce governance body. | 09/30/2015 | 03/31/2016 | 09/30/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | NO |
| **Task**<br>1. Concurrent with developing the transition roadmap, the AFBHC Workforce Committee (WC) will determine immediate training, recruiting, and redeployment needs required in DY1. | In Progress | 1. Concurrent with developing the transition roadmap, the AFBHC Workforce Committee (WC) will determine immediate training, recruiting, and redeployment needs required in DY1. | 09/30/2015 | 12/31/2015 | 12/31/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task**<br>2. The WC will develop workforce governance policies that define how decisions are made and approved regarding workforce resource allocations, hiring, training, and redeployments. | In Progress | 2. The WC will develop workforce governance policies that define how decisions are made and approved regarding workforce resource allocations, hiring, training, and redeployments. | 09/30/2015 | 03/31/2016 | 09/30/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task**<br>3. The WC will develop the Master Workforce Matrix by defining the target workforce state and performing the workforce gap analysis to assist with creating a workforce transition roadmap. | In Progress | 3. The WC will develop the Master Workforce Matrix by defining the target workforce state and performing the workforce gap analysis to assist with creating a workforce transition roadmap. | 09/30/2015 | 03/31/2016 | 09/30/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task**<br>4. The WC will add a timeline to the Master Workforce Matrix outlining when workforce trainings, hirings, and redeployments are expected to take place. | In Progress | 4. The WC will add a timeline to the Master Workforce Matrix outlining when workforce trainings, hirings, and redeployments are expected to take place. | 09/30/2015 | 03/31/2016 | 09/30/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task**<br>5. The WC will establish a schedule of Workforce Outcomes, by DSRIP year, against which workforce transitions progress can be measured on a regular basis. | In Progress | 5. The WC will establish a schedule of Workforce Outcomes, by DSRIP year, against which workforce transitions progress can be measured on a regular basis. | 09/30/2015 | 03/31/2016 | 09/30/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task**<br>6. The WC shall consider PAC suggestions and recommendations into further developing the workforce transition roadmap. | In Progress | 6. The WC shall consider PAC suggestions and recommendations into further developing the workforce transition roadmap. | 09/30/2015 | 03/31/2016 | 09/30/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |

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| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| **Task** 7. The WC shall present the workforce transition roadmap to the Board of Managers for approval. | In Progress | 7. The WC shall present the workforce transition roadmap to the Board of Managers for approval. | 09/30/2015 | 03/31/2016 | 09/30/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Milestone #3** Perform detailed gap analysis between current state assessment of workforce and projected future state. | In Progress | Current state assessment report & gap analysis, signed off by PPS workforce governance body. | 09/30/2015 | 03/31/2016 | 09/30/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | NO |
| **Task** 1. The AFBHC Workforce Committee (WC) will develop the methodology to collect workforce census information from its committed providers. Information to include position counts, position vacancies, etc. | In Progress | 1. The AFBHC Workforce Committee (WC) will develop the methodology to collect workforce census information from its committed providers. Information to include position counts, position vacancies, etc. | 09/30/2015 | 12/31/2015 | 12/31/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task** 2. The WC will collect and report quarterly all required workforce information throughout the duration of the DSRIP project. | In Progress | 2. The WC will collect and report quarterly all required workforce information throughout the duration of the DSRIP project. | 09/30/2015 | 03/31/2016 | 09/30/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task** 3. The WC will summarize into a Master Workforce Matrix, all workforce items as specified and required by DOH for Domain 1, including Domain 1 project requirements; implementation plan workforce requirements; data collections from the target workforce state; and the workforce commitments made by the PPS in their organizational and project applications. | In Progress | 3. The WC will summarize into a Master Workforce Matrix, all workforce items as specified and required by DOH for Domain 1, including Domain 1 project requirements; implementation plan workforce requirements; data collections from the target workforce state; and the workforce commitments made by the PPS in their organizational and project applications. | 09/30/2015 | 03/31/2016 | 09/30/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task** 4. The WC will utilize the Master Workforce Matrix to identify gaps and determine what steps will need to be taken for each provider to meet their respective workforce needs. | In Progress | 4. The WC will utilize the Master Workforce Matrix to identify gaps and determine what steps will need to be taken for each provider to meet their respective workforce needs. | 09/30/2015 | 03/31/2016 | 09/30/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task** 5. The WC shall consider PAC suggestions and recommendations in the gap analysis. | In Progress | 5. The WC shall consider PAC suggestions and recommendations in the gap analysis. | 09/30/2015 | 03/31/2016 | 09/30/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task** 6. The WC will provide a final updated and required Workforce Strategy Budget, Workforce | In Progress | 6. The WC will provide a final updated and required Workforce Strategy Budget, Workforce Impact Analysis, and New Hire Employment Analysis for the DY1, Q4 quarterly | 09/30/2015 | 03/31/2016 | 09/30/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |

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| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| Impact Analysis, and New Hire Employment Analysis for the DY1, Q4 quarterly report. | | report. | | | | | | | |
| **Task**<br>7. The WC will define the detailed gap analysis between the current and future state of the PPS workforce and present to the AFBHC Board for approval. | In Progress | 7. The WC will define the detailed gap analysis between the current and future state of the PPS workforce and present to the AFBHC Board for approval. | 09/30/2015 | 03/31/2016 | 09/30/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Milestone #4**<br>Produce a compensation and benefit analysis, covering impacts on both retrained and redeployed staff, as well as new hires, particularly focusing on full and partial placements. | In Progress | Compensation and benefit analysis report, signed off by PPS workforce governance body. | 09/30/2015 | 06/30/2016 | 09/30/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 | YES |
| **Task**<br>1. The AFBHC Workforce Committee (WC) will develop the methodology to regularly collect salary and benefit information from its committed providers, with consideration given to utilizing an independent third party to collect and report on the data. | In Progress | 1. The AFBHC Workforce Committee (WC) will develop the methodology to regularly collect salary and benefit information from its committed providers, with consideration given to utilizing an independent third party to collect and report on the data. | 09/30/2015 | 03/31/2016 | 09/30/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task**<br>2. Utilize an independent third party to collect baseline compensation and benefits information from providers for job roles previously identified in the Master Workforce Matrix. | In Progress | 2. Utilize an independent third party to collect baseline compensation and benefits information from providers for job roles previously identified in the Master Workforce Matrix. | 09/30/2015 | 03/31/2016 | 09/30/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task**<br>3. The WC will determine the need and make recommendations to collect/not collect compensation and benefits information for job roles determined as having a low impact for training, hiring, or redeployment. | In Progress | 3. The WC will determine the need and make recommendations to collect/not collect compensation and benefits information for job roles determined as having a low impact for training, hiring, or redeployment. | 09/30/2015 | 03/31/2016 | 09/30/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task**<br>4. The WC will utilize the collected data to prepare a compensation and benefits analysis of the workforce expected to be impacted by training, hiring, or redeployment and present to the Board of Managers for approval. | In Progress | 4. The WC will utilize the collected data to prepare a compensation and benefits analysis of the workforce expected to be impacted by training, hiring, or redeployment and present to the Board of Managers for approval. | 09/30/2015 | 06/30/2016 | 09/30/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 | |
| **Milestone #5** | In Progress | Finalized training strategy, signed off by PPS workforce | 09/30/2015 | 03/31/2016 | 09/30/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | NO |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|---|---|
| Develop training strategy. | | governance body. | | | | | | | |
| **Task** 1. The AFBHC Workforce Committee (WC) will review and assess workforce commitments made in the PPS's Organizational and Project applications to help develop the PPS training strategy. | Completed | 1. The AFBHC Workforce Committee (WC) will review and assess workforce commitments made in the PPS's Organizational and Project applications to help develop the PPS training strategy. | 09/30/2015 | 12/31/2015 | 12/31/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task** 2. Concurrent with developing the training strategy, determine training priorities and needs required in DY1. | In Progress | 2. Concurrent with developing the training strategy, determine training priorities and needs required in DY1. | 09/30/2015 | 12/31/2015 | 12/31/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task** 3. Create a Training Sub-Committee (TSC) comprised of provider staff educators, and other education professionals, that will assist the WC in assessing training priorities, developing the training strategy, identifying timelines, training schedules, and implementation of the training plan. | In Progress | 3. Create a Training Sub-Committee (TSC) comprised of provider staff educators, and other education professionals, that will assist the WC in assessing training priorities, developing the training strategy, identifying timelines, training schedules, and implementation of the training plan. | 09/30/2015 | 12/31/2015 | 12/31/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task** 4. The WC and TSC will utilize the Master Workforce Matrix as a guide to assess the needs of the job roles previously identified as requiring training/retraining. | In Progress | 4. The WC and TSC will utilize the Master Workforce Matrix as a guide to assess the needs of the job roles previously identified as requiring training/retraining. | 09/30/2015 | 03/31/2016 | 12/31/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task** 5. The WC and TSC will utilize the Master Workforce Matrix to match training needs with training providers and their associated costs. | In Progress | 5. The WC and TSC will utilize the Master Workforce Matrix to match training needs with training providers and their associated costs. | 09/30/2015 | 03/31/2016 | 12/31/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task** 6. The WC and TSC will incorporate training timelines into the Master Workforce Matrix. | In Progress | 6. The WC and TSC will incorporate training timelines into the Master Workforce Matrix. | 09/30/2015 | 03/31/2016 | 12/31/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task** 7. The WC and TSC will define and present a training strategy plan to the Board of Managers for their approval. | In Progress | 7. The WC and TSC will define and present a training strategy plan to the Board of Managers for their approval. | 09/30/2015 | 03/31/2016 | 12/31/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IA Instructions / Quarterly Update

| Milestone Name | IA Instructions | Quarterly Update Description |
|---|---|---|

No Records Found

### Prescribed Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|

No Records Found

### Prescribed Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|
| Define target workforce state (in line with DSRIP program's goals). | |
| Create a workforce transition roadmap for achieving defined target workforce state. | Task 1 scheduled for completion 12/31/2015 has been moved to reflect the ongoing nature of the work. |
| Perform detailed gap analysis between current state assessment of workforce and projected future state. | Task 1 scheduled for completion 12/31/2015 has been moved to reflect the ongoing nature of the work. |
| Produce a compensation and benefit analysis, covering impacts on both retrained and redeployed staff, as well as new hires, particularly focusing on full and partial placements. | |
| Develop training strategy. | Tasks 2 and 3 scheduled for completion 12/31/2015 have been moved to reflect the ongoing nature of the work. |

### Milestone Review Status

| Milestone # | Review Status | IA Formal Comments |
|---|---|---|
| **Milestone #1** | Pass & Ongoing | |
| **Milestone #2** | Pass & Ongoing | |
| **Milestone #3** | Pass & Ongoing | |
| **Milestone #4** | Pass & Ongoing | |
| **Milestone #5** | Pass & Ongoing | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 11.3 - PPS Defined Milestones

**Instructions :**

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones.

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|

No Records Found

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# Delivery System Reform Incentive Payment Project

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## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 11.4 - Major Risks to Implementation & Risk Mitigation Strategies

**Instructions :**

Please describe the key challenges and risks that you foresee in achieving the milestones set out above, including potential impacts on specific projects and any risks that will undermine your ability to achieve outcome measure targets.

1) A key challenge for AFBHC will be recruiting for health professionals in shortage occupations to meet the needs and requirements of each project. The AFBHC Workforce Committee will consider establishing a centralized recruitment function that addresses key positions needed.
2) Engaging 1,400 providers in a shared workforce training strategy will be a key challenge. Balancing the many training priorities that AFBHC will be required to fulfill with the workforce priorities of individual providers could be problematic to AFBHC reaching its milestones and metrics. As the AFBHC Workforce Committee develops the overall PPS training strategy, it will address how required trainings will be handled across providers. The use of internet-based communication tools will assist with keeping providers engaged and informed in the workforce training strategy of AFBHC.
3) As providers begin to work together there is a potential threat of the unlawful sharing of compensation and benefits information in violation of federal and state antitrust laws. The AFBHC Workforce Committee will review these laws, in consultation with legal counsel, and develop a policy (or additions to the antitrust policy) for providers to guard against this threat. Further, antitrust protections are afforded AFBHC and its providers if an independent third party collects and reports compensation and benefits data according to antitrust laws.
4) The required reporting of participant-level training data, including outcomes, across all AFBHC providers will be a key challenge. The AFBHC Workforce Committee will consider establishing a Rapid Cycle Team to assist with coordinating workforce reporting functions. Also under consideration will be the use of an internet-based Learning Management System (LMS) to help deliver training content and produce training outcomes reports.
5) An outside threat that could impact most providers within AFBHC is the expected implementation of the ICD-10 medical records coding system in October 2015. Provider priorities may temporarily shift to ICD-10 as payments to providers hinge on accurate coding. AFBHC will consider establishing a multi-provider committee to assess and monitor ICD-10 provider readiness and its potential impact to implementation of AFBHC projects. AFBHC will develop contingency plans in the event provider focus shifts to ICD-10 implementation.

### IPQR Module 11.5 - Major Dependencies on Organizational Workstreams

**Instructions :**

Please describe any interdependencies with other organizational workstreams (IT Systems and Processes, Clinical Integration, etc.)

The overall PPS Workforce Strategy is clearly dependent on other workstreams in the implementation plan. The Governance section requires a finalized workforce communication and engagement plan. The Cultural Competency/Health Literacy section requires developing a training strategy focused on addressing the drivers of health disparities, requiring training plans for clinicians and other segments of the workforce. The IT Systems and Processes section requires developing an IT change management strategy with an education and training plan. The Performance Reporting section requires developing a training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting. The Practitioner Engagement section requires the development of a training/education plan targeting physicians and other

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professional groups, designed to educate them about DSRIP and the PPS-specific quality improvement agenda. The Clinical Integration section requires developing a clinical integration strategy, providing training for providers across care settings and training for operations staff. Each project also has project-specific workforce deliverables that will need to be incorporated into the workforce plan. Developing and implementing the PPS workforce plan will be heavily dependent on provider human resource and staff education departments. The quarterly workforce reporting and required documentation will also be dependent on the participation from provider human resource and staff education departments. Workforce reporting and documentation will be enhanced through information technology that can centrally record participant-level data for training, hiring, and redeployments. Given the significant costs associated with the PPS workforce, it is critical that the Workforce Strategy is developed in conjunction with the Financial Sustainability workstream.

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### IPQR Module 11.6 - Roles and Responsibilities

**Instructions :**

Please list and elaborate upon the key people/organizations responsible for this organizational workstream and describe what their responsibilities involve.

| Role | Name of person / organization (if known at this stage) | Key deliverables / responsibilities |
|---|---|---|
| Workforce Committee (WC) | Committee Members listed below | Responsible for the AFBHC overall workforce strategy. Oversees the Workforce Implementation Plan and the approval of required Milestones within the plan. Responsible for overseeing the collection of data required for workforce quarterly reporting. Coordinates workforce activities with Project Leads. Oversees activities of the Training Sub-Committee (TSC). |
| Workforce Committee Chair | Dave Shippee, President and CEO, Whitney M. Young, Jr. Health Center | Accountable for overseeing and managing the activities of the Workforce Committee (WC) and Training Sub Committee (TSC) |
| Workforce Committee Member | Andrea Thomas, Director of Human Resources, Capital Care | Responsibilities listed above for the Workforce Committee (WC). |
| Workforce Committee Member | Andrew Rodrigue, Director of Human Resources, Community Care | Responsibilities listed above for the Workforce Committee (WC). |
| Workforce Committee Member | Joe Giansante, Vice President of Human Resources, Ellis Medicine | Responsibilities listed above for the Workforce Committee (WC). |
| Workforce Committee Member | Kathy Messore, Chief Human Resources Officer, Hometown Health | Responsibilities listed above for the Workforce Committee (WC). |
| Workforce Committee Member | Al Turo, Interim Vice President Chief Human Resources Officer, St. Mary's Healthcare Amsterdam | Responsibilities listed above for the Workforce Committee (WC). |
| Workforce Committee Member | Barbara McCandless, Vice President Human Resources, St. Peter's Health Partners | Responsibilities listed above for the Workforce Committee (WC). |
| Workforce Committee Member | Matthew Petrin, Vice President Human Resources, Whitney M. Young, Jr. Health Center | Responsibilities listed above for the Workforce Committee (WC). |
| Workforce Committee Member | BobVanZetta, Executive Director, Family & Child Service Schenectady | Responsibilities listed above for the Workforce Committee (WC). |
| Workforce Committee Member | Susan Cipolla, Director of Human Resources, Catholic Charities of the Diocese of Albany | Responsibilities listed above for the Workforce Committee (WC). |
| Workforce Committee Member | TBD, Regulatory Specialist, New York State Nurses Association (NYSNA) | Responsibilities listed above for the Workforce Committee (WC). |
| Workforce Committee Member | TBD, Education Specialist, Higher Education Representative | Responsibilities listed above for the Workforce Committee (WC). |
| Workforce Committee Member | Maureen Tomlinson, Organizer, SEIU 1199 | Responsibilities listed above for the Workforce Committee (WC). |
| Training Sub-Committee (TSC) | Staff Educator representation from Ellis Medicine, St. Peter's Health Partners, St. Mary's Healthcare (Amsterdam), Whitney M. Young Jr. Health Center, Hometown Health Center, Community Care Physicians, and Capital Care Medical Group, and other | Working with the WC, responsible for the development and implementation of the AFBHC training plan. Responsible for coordinating employee training to include focus on employees working with specific poplulations such as developmentally |

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| Role | Name of person / organization (if known at this stage) | Key deliverables / responsibilities |
|---|---|---|
| | provider organizations as determined by the WC. | disabled, homeless, and uninsured. |

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## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 11.7 - Key Stakeholders

**Instructions :**

Please identify the key stakeholders involved in your workforce transformation plans, both within and outside the PPS.

| Key stakeholders | Role in relation to this organizational workstream | Key deliverables / responsibilities |
|---|---|---|
| **Internal Stakeholders** | | |
| Ellis Hospital School of Nursing | Educator | Nursing certifications and training. |
| Samaritan Hospital School of Nursing | Educator | Nursing certifications and training. |
| Memorial Hospital School of Nursing | Educator | Nursing certifications and training. |
| **External Stakeholders** | | |
| Iroquois Healthcare Association | Workforce Consultant | Compensation and benefits data collection and reporting, training partnerships, workforce strategy. |
| Hudson Mohawk AHEC | Workforce Consultant | Local administrator of health care training. |
| SEIU 1199 | Labor Union | Input regarding job impacts resulting from DSRIP projects. |
| CSEA | Labor Union | Input regarding job impacts resulting from DSRIP projects. |
| NYSNA | Labor Union | Input regarding job impacts resulting from DSRIP projects. |
| University at Albany | Educator | Public Health Education, Health Disparities Certificate program |
| Albany College of Pharmacy | Educator | Degree programs and continuing education provider |
| Empire State College | Educator | RN to BSN in Nursing, non-degree nursing education, offers online and part-time programs for existing workers |
| Maria College | Educator | Licensed Practical Nurse (LPN) training, BSN degree program, Health and Occupational Science program, Psychology program |
| Schenectady County Community College | Educator | Chemical Dependency Counseling (A.A.S. and Certificate), Health Studies Certificate, Nursing A.S. Program in cooperation with Ellis Medicine. |
| School of Health Sciences at The Sage Colleges | Educator | Nursing degree programs, Continuing Education for Nurses, Psychology advanced degree programs. |
| Hudson Valley Community College | Educator | Dental Hygiene (A.A.S.), Dental Assisting Certificate, Emergency Medical Technician (A.A.S. & Certificate), Sonography Certificate, Nursing (A.A.S.), Health & Wellness Institute |
| HealthStream | Online Education and Workforce Reporting Services | Online training and Learning Management System (LMS) provider. Education areas include, but are not limited to, Cultural Competency, Health Literacy, Team-Based Transitional & Collaborative Care, Behavorial Health, Population Health |

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| Key stakeholders | Role in relation to this organizational workstream | Key deliverables / responsibilities |
|---|---|---|
| | | Management, and Leadership Development. |

## IPQR Module 11.8 - IT Expectations

**Instructions :**

Please describe how the development of shared IT infrastructure across the PPS will support your plans for workforce transformation.

1. AFBHC is well positioned to use an existing and continuously developing IT infrastructure that the health care workforce will utilize to coordinate patient care. Most AFBHC partner organizations are already connected together within the Health Information Exchange of New York (HIXNY). HIXNY is the Regional Health Information Organization (RHIO) that serves as the hub to securely collect and deliver health information in real-time between authorized providers and their authorized employees. Providing real-time data empowers the appropriate health care workforce with meaningful information that can be used to improve population health and meet individual needs one patient at a time. 2. AFBHC will utilize IT-based communication tools to engage the workforce. It is expected that electronic newsletters will be used to communicate with employees within AFBHC. The AFBHC website will also have a workforce section outlining workforce efforts being undertaken, including an employment recruitment section to direct individuals to provider organization's job opportunities within AFBHC. 3. A shared IT infrastructure will also support an internet-based centralized delivery system of required and optional training courses across providers within AFBHC. Known as a Learning Management System (LMS), the LMS is also an important tool in recording and reporting on workforce related outcomes at the individual employee level.

## IPQR Module 11.9 - Progress Reporting

**Instructions :**

Please describe how you will measure the success of this organizational workstream.

The success of the AFBHC workforce strategy will predominantly be measured in DY1/DY2 against milestones, actions steps, target dates, and Domain 1 required workforce metrics. In succeeding years, emphasis will increasingly move from pay-for-reporting to pay-for-performance. Ultimately, the success of the workforce strategy will be measured against AFBHC meeting its outcome metrics for each DSRIP project. AFBHC must be able to regularly measure if the investments made in its workforce strategy are having a positive impact on the ability of AFBHC to meet its stated goals and project outcomes. AFBHC will consider establishing a centralized workforce reporting function to assist with reporting new hire activity, workforce impacts, and workforce budget spending. An internet-based Learning Management System (LMS) will be an important tool in being able to centrally collect, record, and report on workforce outcomes. Through an LMS, online training courses can be assigned to employees across multiple providers within the PPS. The LMS automatically records training progress and completions for each employee. Most courses have pass/fail thresholds that must be met in order for a course to be considered complete. Where thresholds are not being met, the LMS can be used to identify employees requiring remediation activities. In addition, the LMS has the capability to enter and record training outcomes that are provided in other settings such as classroom training. The LMS has full reporting capabilities to produce detail and summary reports for selected time periods to assist with preparing quarterly reports. The LMS reports can also be used by the Workforce Committee (WC) and the Training Sub-Committee (TSC) to monitor training progress at provider organizations within the PPS. Many providers within AFBHC have experience using

| |
|---|
| online Learning Management Systems and it is expected that administrative staff from these providers will assist with managing the LMS processes and producing the necessary reporting for the WC use. |

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### IPQR Module 11.10 - Staff Impact

**Instructions :**

Please include details on workforce staffing impacts on an annual basis. For each DSRIP year, please indicate the number of individuals in each of the categories below that will be impacted. 'Impacted' is defined as those individuals that are retrained, redeployed, recruited, or whose employment is otherwise affected.

| Staff Type | Workforce Staffing Impact Analysis | | | | | |
|---|---|---|---|---|---|---|
| | DY1 | DY2 | DY3 | DY4 | DY5 | Total Impact |
| **Physicians** | **0** | **0** | **0** | **0** | **0** | **0** |
| Primary Care | 0 | 0 | 0 | 0 | 0 | **0** |
| Other Specialties (Except Psychiatrists) | 0 | 0 | 0 | 0 | 0 | **0** |
| **Physician Assistants** | **0** | **0** | **0** | **0** | **0** | **0** |
| Primary Care | 0 | 0 | 0 | 0 | 0 | **0** |
| Other Specialties | 0 | 0 | 0 | 0 | 0 | **0** |
| **Nurse Practitioners** | **0** | **0** | **0** | **0** | **0** | **0** |
| Primary Care | 0 | 0 | 0 | 0 | 0 | **0** |
| Other Specialties (Except Psychiatric NPs) | 0 | 0 | 0 | 0 | 0 | **0** |
| **Midwives** | **0** | **0** | **0** | **0** | **0** | **0** |
| Midwives | 0 | 0 | 0 | 0 | 0 | **0** |
| **Nursing** | **0** | **0** | **0** | **0** | **0** | **0** |
| Nurse Managers/Supervisors | 0 | 0 | 0 | 0 | 0 | **0** |
| Staff Registered Nurses | 0 | 0 | 0 | 0 | 0 | **0** |
| Other Registered Nurses (Utilization Review, Staff Development, etc.) | 0 | 0 | 0 | 0 | 0 | **0** |
| LPNs | 0 | 0 | 0 | 0 | 0 | **0** |
| Other | 0 | 0 | 0 | 0 | 0 | **0** |
| **Clinical Support** | **0** | **0** | **0** | **0** | **0** | **0** |
| Medical Assistants | 0 | 0 | 0 | 0 | 0 | **0** |
| Nurse Aides/Assistants | 0 | 0 | 0 | 0 | 0 | **0** |
| Patient Care Techs | 0 | 0 | 0 | 0 | 0 | **0** |

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| Staff Type | Workforce Staffing Impact Analysis | | | | | |
|---|---|---|---|---|---|---|
| | DY1 | DY2 | DY3 | DY4 | DY5 | Total Impact |
| Clinical Laboratory Technologists and Technicians | 0 | 0 | 0 | 0 | 0 | **0** |
| Other | 0 | 0 | 0 | 0 | 0 | **0** |
| **Behavioral Health (Except Social Workers providing Case/Care Management, etc.)** | **0** | **0** | **0** | **0** | **0** | **0** |
| Psychiatrists | 0 | 0 | 0 | 0 | 0 | **0** |
| Psychologists | 0 | 0 | 0 | 0 | 0 | **0** |
| Psychiatric Nurse Practitioners | 0 | 0 | 0 | 0 | 0 | **0** |
| Licensed Clinical Social Workers | 0 | 0 | 0 | 0 | 0 | **0** |
| Substance Abuse and Behavioral Disorder Counselors | 0 | 0 | 0 | 0 | 0 | **0** |
| Other Mental Health/Substance Abuse Titles Requiring Certification | 0 | 0 | 0 | 0 | 0 | **0** |
| Social and Human Service Assistants | 0 | 0 | 0 | 0 | 0 | **0** |
| Psychiatric Aides/Techs | 0 | 0 | 0 | 0 | 0 | **0** |
| Other | 0 | 0 | 0 | 0 | 0 | **0** |
| **Nursing Care Managers/Coordinators/Navigators/Coaches** | **0** | **0** | **0** | **0** | **0** | **0** |
| RN Care Coordinators/Case Managers/Care Transitions | 0 | 0 | 0 | 0 | 0 | **0** |
| LPN Care Coordinators/Case Managers | 0 | 0 | 0 | 0 | 0 | **0** |
| **Social Worker Case Management/Care Management** | **0** | **0** | **0** | **0** | **0** | **0** |
| Bachelor's Social Work | 0 | 0 | 0 | 0 | 0 | **0** |
| Licensed Masters Social Workers | 0 | 0 | 0 | 0 | 0 | **0** |
| Social Worker Care Coordinators/Case Managers/Care Transition | 0 | 0 | 0 | 0 | 0 | **0** |
| Other | 0 | 0 | 0 | 0 | 0 | **0** |
| **Non-licensed Care Coordination/Case Management/Care Management/Patient Navigators/Community Health Workers (Except RNs, LPNs, and Social Workers)** | **0** | **0** | **0** | **0** | **0** | **0** |
| Care Manager/Coordinator (Bachelor's degree required) | 0 | 0 | 0 | 0 | 0 | **0** |
| Care or Patient Navigator | 0 | 0 | 0 | 0 | 0 | **0** |
| Community Health Worker (All education levels and training) | 0 | 0 | 0 | 0 | 0 | **0** |

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| Staff Type | Workforce Staffing Impact Analysis | | | | | |
|---|---|---|---|---|---|---|
| | DY1 | DY2 | DY3 | DY4 | DY5 | Total Impact |
| Peer Support Worker (All education levels) | 0 | 0 | 0 | 0 | 0 | **0** |
| Other Requiring High School Diplomas | 0 | 0 | 0 | 0 | 0 | **0** |
| Other Requiring Associates or Certificate | 0 | 0 | 0 | 0 | 0 | **0** |
| Other Requiring Bachelor's Degree or Above | 0 | 0 | 0 | 0 | 0 | **0** |
| Other Requiring Master's Degree or Above | 0 | 0 | 0 | 0 | 0 | **0** |
| **Patient Education** | **0** | **0** | **0** | **0** | **0** | **0** |
| Certified Asthma Educators | 0 | 0 | 0 | 0 | 0 | **0** |
| Certified Diabetes Educators | 0 | 0 | 0 | 0 | 0 | **0** |
| Health Coach | 0 | 0 | 0 | 0 | 0 | **0** |
| Health Educators | 0 | 0 | 0 | 0 | 0 | **0** |
| Other | 0 | 0 | 0 | 0 | 0 | **0** |
| **Administrative Staff -- All Titles** | **0** | **0** | **0** | **0** | **0** | **0** |
| Executive Staff | 0 | 0 | 0 | 0 | 0 | **0** |
| Financial | 0 | 0 | 0 | 0 | 0 | **0** |
| Human Resources | 0 | 0 | 0 | 0 | 0 | **0** |
| Other | 0 | 0 | 0 | 0 | 0 | **0** |
| **Administrative Support -- All Titles** | **0** | **0** | **0** | **0** | **0** | **0** |
| Office Clerks | 0 | 0 | 0 | 0 | 0 | **0** |
| Secretaries and Administrative Assistants | 0 | 0 | 0 | 0 | 0 | **0** |
| Coders/Billers | 0 | 0 | 0 | 0 | 0 | **0** |
| Dietary/Food Service | 0 | 0 | 0 | 0 | 0 | **0** |
| Financial Service Representatives | 0 | 0 | 0 | 0 | 0 | **0** |
| Housekeeping | 0 | 0 | 0 | 0 | 0 | **0** |
| Medical Interpreters | 0 | 0 | 0 | 0 | 0 | **0** |
| Patient Service Representatives | 0 | 0 | 0 | 0 | 0 | **0** |
| Transportation | 0 | 0 | 0 | 0 | 0 | **0** |

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## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Staff Type | Workforce Staffing Impact Analysis | | | | | |
|---|---|---|---|---|---|---|
| | DY1 | DY2 | DY3 | DY4 | DY5 | Total Impact |
| Other | 0 | 0 | 0 | 0 | 0 | **0** |
| **Janitors and cleaners** | **0** | **0** | **0** | **0** | **0** | **0** |
| Janitors and cleaners | 0 | 0 | 0 | 0 | 0 | **0** |
| **Health Information Technology** | **0** | **0** | **0** | **0** | **0** | **0** |
| Health Information Technology Managers | 0 | 0 | 0 | 0 | 0 | **0** |
| Hardware Maintenance | 0 | 0 | 0 | 0 | 0 | **0** |
| Software Programmers | 0 | 0 | 0 | 0 | 0 | **0** |
| Technical Support | 0 | 0 | 0 | 0 | 0 | **0** |
| Other | 0 | 0 | 0 | 0 | 0 | **0** |
| **Home Health Care** | **0** | **0** | **0** | **0** | **0** | **0** |
| Certified Home Health Aides | 0 | 0 | 0 | 0 | 0 | **0** |
| Personal Care Aides | 0 | 0 | 0 | 0 | 0 | **0** |
| Other | 0 | 0 | 0 | 0 | 0 | **0** |
| **Other Allied Health** | **0** | **0** | **0** | **0** | **0** | **0** |
| Nutritionists/Dieticians | 0 | 0 | 0 | 0 | 0 | **0** |
| Occupational Therapists | 0 | 0 | 0 | 0 | 0 | **0** |
| Occupational Therapy Assistants/Aides | 0 | 0 | 0 | 0 | 0 | **0** |
| Pharmacists | 0 | 0 | 0 | 0 | 0 | **0** |
| Pharmacy Technicians | 0 | 0 | 0 | 0 | 0 | **0** |
| Physical Therapists | 0 | 0 | 0 | 0 | 0 | **0** |
| Physical Therapy Assistants/Aides | 0 | 0 | 0 | 0 | 0 | **0** |
| Respiratory Therapists | 0 | 0 | 0 | 0 | 0 | **0** |
| Speech Language Pathologists | 0 | 0 | 0 | 0 | 0 | **0** |
| Other | 0 | 0 | 0 | 0 | 0 | **0** |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

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# New York State Department Of Health
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## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

**IPQR Module 11.11 - IA Monitoring:**

**Instructions :**

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

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### Project 2.a.i – Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management

#### IPQR Module 2.a.i.1 - Major Risks to Implementation and Mitigation Strategies

**Instructions :**

Please describe what the major risks are for this project, as well as the actions you plan to take to mitigate them.

The AFBHC plan has aimed to provide the broad array of services to address the needs identified in the CNA and has not yet addressed the specific demands on the partners and stakeholders for implementing the selected projects and if the current drill down of the PPS can match the demand in services created by the selected DSRIP projects. A major risk to the successful completion of Project 2.a.i. is that the aggressive speed and scale targets for provider and patient engagement may outpace the PPS's capacity to meet those targets within the designated timelines. To mitigate this strategy, the AFBHC will conduct capacity assessments and gap analysis. The risk mitigation strategy is to establish an ongoing method for monitoring capacity with demand for services. A dashboard report documenting current capacity compared, projected capacity based on the patient and provider engagement timelines, identified gaps, the nature of those gaps, and what has been / being done to reduce gaps. This dashboard will be reported to the governing board on a quarterly basis for review, evaluation, and action.
The second risk to the successful completion of Project 2.a.i. is that the time limitations for completing the DSRIP CNA, the DSRIP organizational and project applications and the implementation plan has resulted in the lack of knowledge and widespread participation of physician providers in the DSRIP initiative to date. Physician participation and engagement are the foundations of successful system transition. To mitigate this risk, the AFBHC has taken active steps toward provider participation:
1) Dr. Thomas Lawrence, CMO at St. Peter's Health Partners Medical Associates is now an active member of the steering committee.
2) Physician leaders will be added to the AFBHC governing board.
3) The AFBHC and IHANY (the newly established regional ACO) have initiated collaboration between their respective Clinical Integration and Quality Committees to promote alignment, avoid duplication and streamline provider time requirements for participation in administrative activities associated with both organizations.
4) The AFBHC will invite provider participation on the practitioner engagement implementation plan team.
5) The AFBHC will map specific provider roles for each project so these expectations may be included in their operating agreements
6) The AFBHC will plan a comprehensive educational effort using a variety of methods and leveraging physician champions.
7) The AFBHC will establish financial incentives to reward achievement of quality targets.
8) The AFBHC will offer change support, tools, and training from the PPS administrative offices to primary care practices. The success of the mitigation efforts will be documented by the signed operating agreements and distribution of incentives.

Another risk to the successful completion of this project is that the PPS does not achieve NCQA recognition for its primary care practices by DY3, Q4. To mitigate this risk, the PPS will dedicate at least one project manager to focus on PCMH certification and keep on target for the timeline. Current state of the practices will be assessed, technical assistance needs identified and technical assistance will be provided from the PPS central project management office.

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

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### IPQR Module 2.a.i.2 - Prescribed Milestones

**Instructions :**

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for prescribed milestones. For milestones that are due and completed within the reporting period, documentation is required to provide evidence of project requirement achievement. Any explanations regarding altered or missed provider commitments should be included within the narrative box, not as text within uploaded documentation.

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| **Milestone #1**<br>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. | Project | N/A | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>PPS includes continuum of providers in IDS, including medical, behavioral health, post-acute, long-term care, and community-based providers. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>1. Complete full provider list of all AFBHC participants, including medical, behavioral, post-acute and long term care providers | Project | | Completed | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 |
| **Task**<br>2. Assess and catalogue the PPS partners and stakeholder organizations clinical providers: physicians, physician's assistants, nurse practitioners, behavioral health providers, clinical psychologists, clinical social workers, Community based service providers, social services and other MEB disorders care professionals.<br><br>Include: provider name, type, NPI, specialty, solo or group practice, practice size, number of open slots for new patients; PCMH status, presence and role of care coordination. | Project | | Completed | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 |
| **Task**<br>3. Coordinate clinical assessments with assessment of IT capabilities (refer to Part I IT Systems and Processes and Population Health Management) to identify IT strengths and gaps. | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |

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| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| **Task** 4. Building upon the description of the list of stakeholders and community engagement organizations presented in the DSRIP Project Plan application, conduct a drill-down assessment of the specific services provided by each stakeholder organization and how many clients/patients may be added to the their current case load with existing resources. | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 5. Assess the Medicaid MCOs in the PPS service area, including CDPHP, MVP and Fidelis to engage in discussions regarding project-related issues and VBP. Evaluate MCO's Medicaid provider networks and compare and contrast to AFBHC network. Determine any follow up strategies depending on findings | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 6. Project teams, Workforce leaders, and PPS administrative office staff will collaborate to conduct a network gap analysis and develop subsequent plan to fill gaps. Report findings to appropriate stakeholders including the Clinical Integration and Quality Committee | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 7. Project future capacity needs per DSRIP project based on the patient and provider engagement timelines identify gaps or oversupply of the network. | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 8. Develop a plan with timelines to meet those gaps based on the patient and provider engagement timelines | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 9. Develop a dashboard of current capacity compared to projected capacity based on the patient and provider engagement timelines and distribute to pertinent internal stakeholders. | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 10. Determine list of elements that need to be included in the provider agreements/contract and distribute and negotiate with providers. | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 11. Finalize participation agreements/contracts | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 12. Create a process to track all executed provider | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |

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| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| agreements/contracts | | | | | | | | | |
| **Task** 13. Create process and dashboard platform to track provider contracts, requirements, terms and corrective actions | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 14. Report dashboards to the Governing Board on a quarterly basis for review, evaluation and action. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 15. Establish process for the periodic review of provider network lists to fill in the timely clinical and operational service gaps | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Milestone #2** Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** PPS produces a list of participating HHs and ACOs. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** Participating HHs and ACOs demonstrate real service integration which incorporates a population management strategy towards evolving into an IDS. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** Regularly scheduled formal meetings are held to develop collaborative care practices and integrated service delivery. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 1. Establish a planning process and re-occurring meetings with the AFBHC three partner Health Homes (Samaritan Hospital DBA Capital Region Health Connection; St Mary's HealthCare, Amsterdam, Visiting Nurse Service of Schenectady County, Inc. DBA Visiting Nurse Service of Northeastern New York) and IHANY ACO to develop a strategy that develops into an Integrated Delivery System. | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 2. Conduct inventory of the population health management strategies and capabilities that have been adopted by the three partner Health Homes, the IHANY ACO, and compare capabilities to DSRIP requirements. | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 3. Develop an ideal population health management model that leverages best practices from each entity. | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |

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| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>4. As part of the Part I IT Systems and Processes plan, assess the population health management IT tools and systems used by the three Health Homes, seven key partners, IHANY and other partners throughout the PPS (refer to Part 1 IT Systems and Processes). Include: gaps in care Identification capabilities, risk stratification capability, patient outreach & engagement capability, patient care and tracking capability, patient to provider attribution capabilities. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>5. Coordinate strategy for Population Health IT tools and software with IHANY, Health Homes, and community providers (refer to Part I Clinical Integration). | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #3**<br>Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>Clinically Interoperable System is in place for all participating providers. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are followed. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>PPS trains staff on IDS protocols and processes. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>1. Create the AFBHC centralized Clinical Integration and Quality Department to coordinate and align care management across the PPS. | Project | | Completed | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 |
| **Task**<br>2. Identify and document care management best practices from the Medicaid Health Homes, the Comprehensive Primary Care Initiative (CPCI) participants, and NCQA recognized PCMHs | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |

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| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| 3. Incorporating best practices, document with a flow diagram the care management workflow / patient flow among the PPS partners and CBOs. | | | | | | | | | |
| **Task**<br>4. Select the care transitions model(s) that will be endorsed by the PPS and define the transitions workflow / patient flow among the PPS partners and CBOs, including discharges from SNFs. | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task**<br>5. Formally adopt and operationalize the AFBHC Population Health Management Model that cares for people within a PCMH/behavioral/mental health foundation surrounded by a comprehensive integrated network inclusive of medical specialists, acute, post-acute, community based and social services. The model is inclusive of risk-stratification of populations with attendant prevention and wellness interventions with effective transitions and care coordination processes. The model is supported by robust technology, timely actionable analytics, and actuarially-sound payment models from managed care organizations. Conduct subsequent steps within the context of this model. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>6. Incorporating identified best practices, revise care management job descriptions to demonstrate the interrelated care management roles of the Health Homes, Home Care, downstream providers, acute inpatient care management, primary care, outpatient behavioral care, social services, public health organizations, state mental health agencies and care transitions programs | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>7. Incorporate and implement revised care management roles in Projects 2.b.iii., 3.a.i., 3.a.iv., 3.d.ii., 3.g.i. and 4.a.iii. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>8. Implement selected care transitions model in Projects 2.b.iv. and 2.b.viii | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #4**<br>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 | Project | N/A | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |

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| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| clinical partners, including directed exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3. | | | | | | | | | |
| **Task** EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | Provider | Safety Net Practitioner - Primary Care Provider (PCP) | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | Provider | Safety Net Practitioner - Non-Primary Care Provider (PCP) | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | Provider | Safety Net Hospital | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | Provider | Safety Net Mental Health | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | Provider | Safety Net Nursing Home | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** PPS uses alerts and secure messaging functionality. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 1. Survey participating providers to understand current infrastructure and connectivity to HIXNY | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 2. Determine requirements for HIXNY connectivity among partners. Assess current systems capability against these requirements. | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 3. Create a gap analysis based on the current state analysis to determine incremental IT needs and associated budget, including short-term manual solutions. | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 4. Develop a roll-out plan for systems to achieve sharing health information among clinical partners, including a training plan to support the successful implementation of new platforms and processes | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 5. Establish a process for monitoring project milestones and performance | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| **Task** 6. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 7. Align Project implementation timelines with respective IT timeline to ensure IT requirements are in place for project implementation. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 8. Where EHR functionality is not yet ready, implement alternate in the interim. Track conversion to electronic systems. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 9. Coordinate with IT Systems and Processes for the roadmap to achieving clinical data sharing and interoperable systems across PPS network | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 10. Collaborate with hospital systems and IT to assess and edit current policies and protocols around actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **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. | Project | N/A | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria). | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM. | Provider | Safety Net Practitioner - Primary Care Provider (PCP) | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 1. Survey participating providers to understand their use of EHR's and PCMH status and level | Project | | Completed | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 |
| **Task** 2. Determine requirements for meeting Meaningful Use and PCMH level 3 standards. Assess current systems capability against these requirements. | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |

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| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| **Task** 3. Create a gap analysis based on the current state analysis to determine incremental needs and associated budget | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task** 4. Develop a roll-out plan for systems to achieve Meaningful Use and PCMH level 3 certification, including a training plan to support the successful implementation of new platforms and processes. | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task** 5. Establish a project management process and tool for monitoring project milestones and performance | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 6. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 7. Track progress toward PCMH Level 3 recognition, including progress toward meaning use. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Milestone #6** Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers. | Project | N/A | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 1. Define populations for which registries are needed based on current data available through portals such as Salient | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 09/30/2016 | 09/30/2016 | DY2 Q2 |
| **Task** 2. Survey Participating partners to determine requirements for population health strategy and requirements | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 09/30/2016 | 09/30/2016 | DY2 Q2 |
| **Task** 3. Create a gap analysis based on the current state analysis to determine incremental IT needs and associated budget, including short-term manual solutions | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2016 | 12/31/2016 | DY2 Q3 |
| **Task** 4. Develop a roll-out plan for systems and IT platforms including patient registries among clinical partners, including a training plan to support the successful implementation of new platforms | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2016 | 12/31/2016 | DY2 Q3 |

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| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| and processes | | | | | | | | | |
| **Task** 5. Establish a process for monitoring project milestones and performance metrics | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 6. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPs | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 7. Where EHR functionality is not yet ready, implement alternate in the interim. Track conversion to electronic systems. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 8. Coordinate strategy for Population Health IT tools and software with IHANY (refer to Part I Clinical Integration) and the IT Roadmap (refer to Part I IT Systems and Processes). | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Milestone #7** Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3. | Project | N/A | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** Primary care capacity increases improved access for patients seeking services - particularly in high-need areas. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** All practices meet 2014 NCQA Level 3 PCMH and/or APCM standards. | Provider | Practitioner - Primary Care Provider (PCP) | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.) | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 1. Designate a PPS level PCMH project lead | Project | | Completed | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 |
| **Task** 2. Establish PCMH project team | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 3. Finalize strategy for achieving PCMH Level 3 certification for contracted providers | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task** 4. Classify providers according to criteria to their level of NCQA | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| qualification: not recognized, Level 1, 2, and 3 using 2011 standards, and those that are in process of applying for 2014 standards. | | | | | | | | | |
| **Task** 5. Classify providers according to criteria required to meet Meaningful Use Stage 2 requirements | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task** 6. Based on analysis of pros/cons of corporate vs individual practice NCQA PCMH recognition, select approach(es) for provider groups | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task** 7. Determine level of support with financial implications for AFBHC | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task** 8. Assess level of administrative and financial support that MCO's in the region are currently providing or planning to provide primary care practices to help them achieve PCMH Level 2014 standards to ensure there is coordination and no duplication of effort. | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task** 9. Collect NCQA recognition documentation from practices that are currently 2014 or 2011 Level 3 recognized | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task** 10. PCMH project team to finalize roadmap for achieving Meaningful Use with providers | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task** 11. Establish goals and timelines to achieve 2014 Level 3 NCQA recognition by the end of DY3. | Project | | In Progress | 04/01/2015 | 12/31/2017 | 04/01/2015 | 12/31/2017 | 12/31/2017 | DY3 Q3 |
| **Task** 12. Identify practices participating in projects whose implementation success depends on them achieving 2014 recognition and target them to achieve recognition first. (2.b.iii, 2.b.iii, 3.a.i.) | Project | | In Progress | 04/01/2015 | 12/31/2017 | 04/01/2015 | 12/31/2017 | 12/31/2017 | DY3 Q3 |
| **Task** 13. Establish goals and timelines to achieve 2014 Level 3 NCQA recognition by the end of DY3, starting with practices currently in progress. | Project | | In Progress | 04/01/2015 | 12/31/2017 | 04/01/2015 | 12/31/2017 | 12/31/2017 | DY3 Q3 |
| **Task** 14. Asses the practices' needs for technical assistance and | Project | | In Progress | 04/01/2015 | 12/31/2017 | 04/01/2015 | 12/31/2017 | 12/31/2017 | DY3 Q3 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| provide technical assistance. | | | | | | | | | |
| **Task**<br>15. Track providers progress on quarterly basis for meeting requirements within projected roadmap and take corrective action and or celebrate depending on results | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Milestone #8**<br>Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements. | Project | N/A | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>Medicaid Managed Care contract(s) are in place that include value-based payments. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>1. Establish the structure and process for MCO leadership, and representatives from the PPS Clinical Integration Committee, PPS Finance Committee, IHANY, PPS executives, and other stakeholders as needed to establish the plan for the development of a value-based payment strategy. (Refer to Part 1 Governance). | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task**<br>2. Using the structure and process established, create value-based incentive arrangement models appropriate for the AFBHC and its partners. | Project | | In Progress | 04/01/2015 | 09/30/2016 | 04/01/2015 | 09/30/2016 | 09/30/2016 | DY2 Q2 |
| **Task**<br>3. Research and evaluate different models of value-based payment arrangements referencing, including but not limited to: CMS-approved "A Path Toward Value Based Payment, New York State Roadmap for Medicaid Payment Reform" (June 2015). | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #9**<br>Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>PPS holds monthly meetings with Medicaid Managed Care plans to evaluate utilization trends and performance issues and ensure payment reforms are instituted. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>1. Establish the structure and process to meet regularly with MCOs to review and evaluate costs, quality, and utilization | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |

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# Delivery System Reform Incentive Payment Project

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| **Task** 2. Define participants: MCOs, PPS / IHANY clinical integration committee, PPS finance committee, and other stakeholders as indicated | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 3. Define monthly meeting schedule. | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 4. Define data series of utilization and performance measures to track and Develop data reports | Project | | In Progress | 04/01/2015 | 06/30/2016 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task** 5. Establish a process to provide feedback to selected governance or operational bodies on a regular basis to review data; resolve performance gaps; and report back progress | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 6. Include the following issues identified in the projects: Including but not limited to: 2.a.i, 2.b.iv, 2.d.i, 3.a.iv, 3.d.2, 3.g.i, and 4.b.i | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #10** Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes. | Project | N/A | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** PPS submitted a growth plan outlining the strategy to evolve provider compensation model to incentive-based compensation | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** Providers receive incentive-based compensation consistent with DSRIP goals and objectives. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 1. Build infrastructure for collecting, reporting and ensuring the quality of provider performance data is available for performance tracking and subsequent incentive payments. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 2. Establish a process to identify and resolve documentation gaps that may affect performance reporting. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 3. Establish incentive compensation to patient outcomes consistent with DSRIP goals considering the budget and funds flow framework. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 4. Develop VBP Educational Program explaining the content and implications of Level 1, 2, and 3 Value Based Payments as it | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| refers to: all care for total population, integrated primary care, acute and chronic bundles, and total care subpopulations: New York State Roadmap for Medicaid Payment Reform (June 2015). | | | | | | | | | |
| **Task** 5. Establish communication schedule to present the VBP Educational Program | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 6. Model agreed-upon value-based payment arrangements that align incentives with outcomes, are actuarially sound, and are acceptable to the network and share findings with appropriate stakeholders, Finance Committee, and the Board | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 7. Develop a plan that demonstrates how the incentive based payment model would evolve into value based payment model and obtain Board approval. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Milestone #11** Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate. | Project | N/A | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** Community health workers and community-based organizations utilized in IDS for outreach and navigation activities. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 1. Using input from IHANY, results from the community needs assessment, the AFBHC PPS will establish communication methods for providers, community health workers, clients, peers and community organizations outlining short term and long term goals of DSRIP. | Project | | In Progress | 04/01/2015 | 09/30/2016 | 04/01/2015 | 09/30/2016 | 09/30/2016 | DY2 Q2 |
| **Task** 2. Based on Community Needs Assessment, identify chronic diseases that will have outreach programs offered (chronic disease in general, diabetes, end stage renal disease, chronic pain, cancer survivors). | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 3. Determine strategy for apprising community assessment information, including determination of repeating assessment within the DSRIP calendar timeframe | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| **Task** 4. In conjunction with the workforce committee, determine training curriculum for community health workers, including train the trainer methods, learning management system modules, and other educational platforms | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 5. Include Cultural Competency / Health Literacy committee to decide where and how advisors will be used throughout the PPS. Using the AHRQ Working With Patient and Families as Advisors Implementation Handbook as a guide (http://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/strategy1/Strat1_Implement_Hndbook_508_v2.pdf) develop a training program for advisor roles in the PPS. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 6. Engage Medicaid members to participate as ad hoc advisors in the planning and development of programs, processes, and tools to transform healthcare delivery and address health disparities across cultures | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 7. Using marketing avenues, brand developed strategies to drive toward goal of Triple Aim. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 8. Develop strategy, including policy / procedures, expectations, and guidelines for what, when, where, who and how outreach and navigation activities will be carried out. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 9. Implement outreach steps per strategy developed by PPS IDS | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 10. Identify PPS partners for project and ensure those experienced with navigation, community health workers, and peer support is included. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 11. Create an inventory of community partners providing outreach and navigation activities (type, volume, role expectations, characteristics of individual and patient population served) | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 12. Match characteristics of individual and patient population served with offered of services (ex. community-based | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |

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## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| organization, PCMH, clinical program). | | | | | | | | | |
| **Task** 13. Community Health Workers (CHW). Using NY benchmarks as guide (http://nyshealthfoundation.org/uploads/resources/making-the-connection-community-health-workers-sept-2012.pdf), establish roles expectations, selection process, standards, and onboarding curriculum to prepare Community Health Workers for positions in their own communities. Redeploy internal workers as possible. Include developed protocols for engagement. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 14. Establish a Self-Management Education Program (ex. Standard Self-Management Model) that is administered from the PPS level to increase capacity and flexibility of offerings. Choose a model that has been adapted to different cultures and may be taught in multiple languages. (Stanford Chronic Disease Self-Management model or similar program). | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 15. Coordinate activities with patient activation measures in various projects across the PPS, with emphasis on 2di project alignment | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 16. Based on the Community Needs Assessment, identify other populations that could benefit from the program in their native language using language interpretation platforms. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 17. Establish methods to stratify outcomes to quantify disparities, identify target areas and evaluate interventions. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **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. | | | | | | | | | | |

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# Delivery System Reform Incentive Payment Project

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>PPS includes continuum of providers in IDS, including medical, behavioral health, post-acute, long-term care, and community-based providers. | | | | | | | | | | |
| **Task**<br>1. Complete full provider list of all AFBHC participants, including medical, behavioral, post-acute and long term care providers | | | | | | | | | | |
| **Task**<br>2. Assess and catalogue the PPS partners and stakeholder organizations clinical providers: physicians, physician's assistants, nurse practitioners, behavioral health providers, clinical psychologists, clinical social workers, Community based service providers, social services and other MEB disorders care professionals.<br><br>Include: provider name, type, NPI, specialty, solo or group practice, practice size, number of open slots for new patients; PCMH status, presence and role of care coordination. | | | | | | | | | | |
| **Task**<br>3. Coordinate clinical assessments with assessment of IT capabilities (refer to Part I IT Systems and Processes and Population Health Management) to identify IT strengths and gaps. | | | | | | | | | | |
| **Task**<br>4. Building upon the description of the list of stakeholders and community engagement organizations presented in the DSRIP Project Plan application, conduct a drill-down assessment of the specific services provided by each stakeholder organization and how many clients/patients may be added to the their current case load with existing resources. | | | | | | | | | | |
| **Task**<br>5. Assess the Medicaid MCOs in the PPS service area, including CDPHP, MVP and Fidelis to engage in discussions regarding project-related issues and VBP. Evaluate MCO's Medicaid provider networks and compare and contrast to AFBHC network. Determine any follow up strategies depending on findings | | | | | | | | | | |
| **Task**<br>6. Project teams, Workforce leaders, and PPS administrative office staff will collaborate to conduct a network gap analysis and develop subsequent plan to fill gaps. Report findings to appropriate stakeholders including the Clinical Integration and Quality Committee | | | | | | | | | | |
| **Task**<br>7. Project future capacity needs per DSRIP project based on the patient and provider engagement timelines identify gaps or | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| oversupply of the network. | | | | | | | | | | |
| **Task** 8. Develop a plan with timelines to meet those gaps based on the patient and provider engagement timelines | | | | | | | | | | |
| **Task** 9. Develop a dashboard of current capacity compared to projected capacity based on the patient and provider engagement timelines and distribute to pertinent internal stakeholders. | | | | | | | | | | |
| **Task** 10. Determine list of elements that need to be included in the provider agreements/contract and distribute and negotiate with providers. | | | | | | | | | | |
| **Task** 11. Finalize participation agreements/contracts | | | | | | | | | | |
| **Task** 12. Create a process to track all executed provider agreements/contracts | | | | | | | | | | |
| **Task** 13. Create process and dashboard platform to track provider contracts, requirements, terms and corrective actions | | | | | | | | | | |
| **Task** 14. Report dashboards to the Governing Board on a quarterly basis for review, evaluation and action. | | | | | | | | | | |
| **Task** 15. Establish process for the periodic review of provider network lists to fill in the timely clinical and operational service gaps | | | | | | | | | | |
| **Milestone #2** Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS. | | | | | | | | | | |
| **Task** PPS produces a list of participating HHs and ACOs. | | | | | | | | | | |
| **Task** Participating HHs and ACOs demonstrate real service integration which incorporates a population management strategy towards evolving into an IDS. | | | | | | | | | | |
| **Task** Regularly scheduled formal meetings are held to develop collaborative care practices and integrated service delivery. | | | | | | | | | | |
| **Task** 1. Establish a planning process and re-occurring meetings with the AFBHC three partner Health Homes (Samaritan Hospital DBA Capital Region Health Connection; St Mary's HealthCare, | | | | | | | | | | |

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## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| Amsterdam, Visiting Nurse Service of Schenectady County, Inc. DBA Visiting Nurse Service of Northeastern New York) and IHANY ACO to develop a strategy that develops into an Integrated Delivery System. | | | | | | | | | | |
| **Task**<br>2. Conduct inventory of the population health management strategies and capabilities that have been adopted by the three partner Health Homes, the IHANY ACO, and compare capabilities to DSRIP requirements. | | | | | | | | | | |
| **Task**<br>3. Develop an ideal population health management model that leverages best practices from each entity. | | | | | | | | | | |
| **Task**<br>4. As part of the Part I IT Systems and Processes plan, assess the population health management IT tools and systems used by the three Health Homes, seven key partners, IHANY and other partners throughout the PPS (refer to Part 1 IT Systems and Processes). Include: gaps in care Identification capabilities, risk stratification capability, patient outreach & engagement capability, patient care and tracking capability, patient to provider attribution capabilities. | | | | | | | | | | |
| **Task**<br>5. Coordinate strategy for Population Health IT tools and software with IHANY, Health Homes, and community providers (refer to Part I Clinical Integration). | | | | | | | | | | |
| **Milestone #3**<br>Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services. | | | | | | | | | | |
| **Task**<br>Clinically Interoperable System is in place for all participating providers. | | | | | | | | | | |
| **Task**<br>PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS. | | | | | | | | | | |
| **Task**<br>PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are followed. | | | | | | | | | | |
| **Task**<br>PPS trains staff on IDS protocols and processes. | | | | | | | | | | |
| **Task**<br>1. Create the AFBHC centralized Clinical Integration and Quality Department to coordinate and align care management across the | | | | | | | | | | |

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## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| PPS. | | | | | | | | | | |
| **Task**<br>2. Identify and document care management best practices from the Medicaid Health Homes, the Comprehensive Primary Care Initiative (CPCI) participants, and NCQA recognized PCMHs | | | | | | | | | | |
| **Task**<br>3. Incorporating best practices, document with a flow diagram the care management workflow / patient flow among the PPS partners and CBOs. | | | | | | | | | | |
| **Task**<br>4. Select the care transitions model(s) that will be endorsed by the PPS and define the transitions workflow / patient flow among the PPS partners and CBOs, including discharges from SNFs. | | | | | | | | | | |
| **Task**<br>5. Formally adopt and operationalize the AFBHC Population Health Management Model that cares for people within a PCMH/behavioral/mental health foundation surrounded by a comprehensive integrated network inclusive of medical specialists, acute, post-acute, community based and social services. The model is inclusive of risk-stratification of populations with attendant prevention and wellness interventions with effective transitions and care coordination processes. The model is supported by robust technology, timely actionable analytics, and actuarially-sound payment models from managed care organizations. Conduct subsequent steps within the context of this model. | | | | | | | | | | |
| **Task**<br>6. Incorporating identified best practices, revise care management job descriptions to demonstrate the interrelated care management roles of the Health Homes, Home Care, downstream providers, acute inpatient care management, primary care, outpatient behavioral care, social services, public health organizations, state mental health agencies and care transitions programs | | | | | | | | | | |
| **Task**<br>7. Incorporate and implement revised care management roles in Projects 2.b.iii., 3.a.i., 3.a.iv., 3.d.ii., 3.g.i. and 4.a.iii. | | | | | | | | | | |
| **Task**<br>8. Implement selected care transitions model in Projects 2.b.iv. and 2.b.viii | | | | | | | | | | |
| **Milestone #4**<br>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 | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| clinical partners, including directed exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3. | | | | | | | | | | |
| **Task** EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | 0 | 0 | 0 | 0 | 0 | 0 | 5 | 12 | 20 | 30 |
| **Task** EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | 0 | 0 | 0 | 0 | 0 | 0 | 7 | 17 | 28 | 43 |
| **Task** EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 3 | 4 | 7 |
| **Task** EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 9 | 16 | 23 |
| **Task** EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 6 | 9 | 14 |
| **Task** PPS uses alerts and secure messaging functionality. | | | | | | | | | | |
| **Task** 1. Survey participating providers to understand current infrastructure and connectivity to HIXNY | | | | | | | | | | |
| **Task** 2. Determine requirements for HIXNY connectivity among partners. Assess current systems capability against these requirements. | | | | | | | | | | |
| **Task** 3. Create a gap analysis based on the current state analysis to determine incremental IT needs and associated budget, including short-term manual solutions. | | | | | | | | | | |
| **Task** 4. Develop a roll-out plan for systems to achieve sharing health information among clinical partners, including a training plan to support the successful implementation of new platforms and processes | | | | | | | | | | |
| **Task** 5. Establish a process for monitoring project milestones and performance | | | | | | | | | | |
| **Task** 6. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS | | | | | | | | | | |
| **Task** 7. Align Project implementation timelines with respective IT | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| timeline to ensure IT requirements are in place for project implementation. | | | | | | | | | | |
| **Task** 8. Where EHR functionality is not yet ready, implement alternate in the interim. Track conversion to electronic systems. | | | | | | | | | | |
| **Task** 9. Coordinate with IT Systems and Processes for the roadmap to achieving clinical data sharing and interoperable systems across PPS network | | | | | | | | | | |
| **Task** 10. Collaborate with hospital systems and IT to assess and edit current policies and protocols around actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up | | | | | | | | | | |
| **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. | | | | | | | | | | |
| **Task** EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria). | | | | | | | | | | |
| **Task** PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 9 | 21 |
| **Task** 1. Survey participating providers to understand their use of EHR's and PCMH status and level | | | | | | | | | | |
| **Task** 2. Determine requirements for meeting Meaningful Use and PCMH level 3 standards. Assess current systems capability against these requirements. | | | | | | | | | | |
| **Task** 3. Create a gap analysis based on the current state analysis to determine incremental needs and associated budget | | | | | | | | | | |
| **Task** 4. Develop a roll-out plan for systems to achieve Meaningful Use and PCMH level 3 certification, including a training plan to support the successful implementation of new platforms and processes. | | | | | | | | | | |
| **Task** 5. Establish a project management process and tool for monitoring project milestones and performance | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task** 6. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS | | | | | | | | | | |
| **Task** 7. Track progress toward PCMH Level 3 recognition, including progress toward meaning use. | | | | | | | | | | |
| **Milestone #6** Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers. | | | | | | | | | | |
| **Task** PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting. | | | | | | | | | | |
| **Task** 1. Define populations for which registries are needed based on current data available through portals such as Salient | | | | | | | | | | |
| **Task** 2. Survey Participating partners to determine requirements for population health strategy and requirements | | | | | | | | | | |
| **Task** 3. Create a gap analysis based on the current state analysis to determine incremental IT needs and associated budget, including short-term manual solutions | | | | | | | | | | |
| **Task** 4. Develop a roll-out plan for systems and IT platforms including patient registries among clinical partners, including a training plan to support the successful implementation of new platforms and processes | | | | | | | | | | |
| **Task** 5. Establish a process for monitoring project milestones and performance metrics | | | | | | | | | | |
| **Task** 6. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPs | | | | | | | | | | |
| **Task** 7. Where EHR functionality is not yet ready, implement alternate in the interim. Track conversion to electronic systems. | | | | | | | | | | |
| **Task** 8. Coordinate strategy for Population Health IT tools and software with IHANY (refer to Part I Clinical Integration) and the IT Roadmap (refer to Part I IT Systems and Processes). | | | | | | | | | | |
| **Milestone #7** Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3. | | | | | | | | | | |
| **Task** Primary care capacity increases improved access for patients seeking services - particularly in high-need areas. | | | | | | | | | | |
| **Task** All practices meet 2014 NCQA Level 3 PCMH and/or APCM standards. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 84 | 197 |
| **Task** EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.) | | | | | | | | | | |
| **Task** 1. Designate a PPS level PCMH project lead | | | | | | | | | | |
| **Task** 2. Establish PCMH project team | | | | | | | | | | |
| **Task** 3. Finalize strategy for achieving PCMH Level 3 certification for contracted providers | | | | | | | | | | |
| **Task** 4. Classify providers according to criteria to their level of NCQA qualification: not recognized, Level 1, 2, and 3 using 2011 standards, and those that are in process of applying for 2014 standards. | | | | | | | | | | |
| **Task** 5. Classify providers according to criteria required to meet Meaningful Use Stage 2 requirements | | | | | | | | | | |
| **Task** 6. Based on analysis of pros/cons of corporate vs individual practice NCQA PCMH recognition, select approach(es) for provider groups | | | | | | | | | | |
| **Task** 7. Determine level of support with financial implications for AFBHC | | | | | | | | | | |
| **Task** 8. Assess level of administrative and financial support that MCO's in the region are currently providing or planning to provide primary care practices to help them achieve PCMH Level 2014 standards to ensure there is coordination and no duplication of effort. | | | | | | | | | | |
| **Task** 9. Collect NCQA recognition documentation from practices that are currently 2014 or 2011 Level 3 recognized | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task** 10. PCMH project team to finalize roadmap for achieving Meaningful Use with providers | | | | | | | | | | |
| **Task** 11. Establish goals and timelines to achieve 2014 Level 3 NCQA recognition by the end of DY3. | | | | | | | | | | |
| **Task** 12. Identify practices participating in projects whose implementation success depends on them achieving 2014 recognition and target them to achieve recognition first. (2.b.iii, 2.b.iii, 3.a.i.) | | | | | | | | | | |
| **Task** 13. Establish goals and timelines to achieve 2014 Level 3 NCQA recognition by the end of DY3, starting with practices currently in progress. | | | | | | | | | | |
| **Task** 14. Asses the practices' needs for technical assistance and provide technical assistance. | | | | | | | | | | |
| **Task** 15. Track providers progress on quarterly basis for meeting requirements within projected roadmap and take corrective action and or celebrate depending on results | | | | | | | | | | |
| **Milestone #8** Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements. | | | | | | | | | | |
| **Task** Medicaid Managed Care contract(s) are in place that include value-based payments. | | | | | | | | | | |
| **Task** 1. Establish the structure and process for MCO leadership, and representatives from the PPS Clinical Integration Committee, PPS Finance Committee, IHANY, PPS executives, and other stakeholders as needed to establish the plan for the development of a value-based payment strategy. (Refer to Part 1 Governance). | | | | | | | | | | |
| **Task** 2. Using the structure and process established, create value-based incentive arrangement models appropriate for the AFBHC and its partners. | | | | | | | | | | |
| **Task** 3. Research and evaluate different models of value-based payment arrangements referencing, including but not limited to: CMS-approved "A Path Toward Value Based Payment, New York State Roadmap for Medicaid Payment Reform" (June | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| 2015). | | | | | | | | | | |
| **Milestone #9** Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform. | | | | | | | | | | |
| **Task** PPS holds monthly meetings with Medicaid Managed Care plans to evaluate utilization trends and performance issues and ensure payment reforms are instituted. | | | | | | | | | | |
| **Task** 1. Establish the structure and process to meet regularly with MCOs to review and evaluate costs, quality, and utilization | | | | | | | | | | |
| **Task** 2. Define participants: MCOs, PPS / IHANY clinical integration committee, PPS finance committee, and other stakeholders as indicated | | | | | | | | | | |
| **Task** 3. Define monthly meeting schedule. | | | | | | | | | | |
| **Task** 4. Define data series of utilization and performance measures to track and Develop data reports | | | | | | | | | | |
| **Task** 5. Establish a process to provide feedback to selected governance or operational bodies on a regular basis to review data; resolve performance gaps; and report back progress | | | | | | | | | | |
| **Task** 6. Include the following issues identified in the projects: Including but not limited to: 2.a.i, 2.b.iv, 2.d.i, 3.a.iv, 3.d.2, 3.g.i, and 4.b.i | | | | | | | | | | |
| **Milestone #10** Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes. | | | | | | | | | | |
| **Task** PPS submitted a growth plan outlining the strategy to evolve provider compensation model to incentive-based compensation | | | | | | | | | | |
| **Task** Providers receive incentive-based compensation consistent with DSRIP goals and objectives. | | | | | | | | | | |
| **Task** 1. Build infrastructure for collecting, reporting and ensuring the quality of provider performance data is available for performance tracking and subsequent incentive payments. | | | | | | | | | | |
| **Task** 2. Establish a process to identify and resolve documentation gaps that may affect performance reporting. | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>3. Establish incentive compensation to patient outcomes consistent with DSRIP goals considering the budget and funds flow framework. | | | | | | | | | | |
| **Task**<br>4. Develop VBP Educational Program explaining the content and implications of Level 1, 2, and 3 Value Based Payments as it refers to: all care for total population, integrated primary care, acute and chronic bundles, and total care subpopulations: New York State Roadmap for Medicaid Payment Reform (June 2015). | | | | | | | | | | |
| **Task**<br>5. Establish communication schedule to present the VBP Educational Program | | | | | | | | | | |
| **Task**<br>6. Model agreed-upon value-based payment arrangements that align incentives with outcomes, are actuarially sound, and are acceptable to the network and share findings with appropriate stakeholders, Finance Committee, and the Board | | | | | | | | | | |
| **Task**<br>7. Develop a plan that demonstrates how the incentive based payment model would evolve into value based payment model and obtain Board approval. | | | | | | | | | | |
| **Milestone #11**<br>Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate. | | | | | | | | | | |
| **Task**<br>Community health workers and community-based organizations utilized in IDS for outreach and navigation activities. | | | | | | | | | | |
| **Task**<br>1. Using input from IHANY, results from the community needs assessment, the AFBHC PPS will establish communication methods for providers, community health workers, clients, peers and community organizations outlining short term and long term goals of DSRIP. | | | | | | | | | | |
| **Task**<br>2. Based on Community Needs Assessment, identify chronic diseases that will have outreach programs offered (chronic disease in general, diabetes, end stage renal disease, chronic pain, cancer survivors). | | | | | | | | | | |
| **Task**<br>3. Determine strategy for apprising community assessment information, including determination of repeating assessment within the DSRIP calendar timeframe | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task** 4. In conjunction with the workforce committee, determine training curriculum for community health workers, including train the trainer methods, learning management system modules, and other educational platforms | | | | | | | | | | |
| **Task** 5. Include Cultural Competency / Health Literacy committee to decide where and how advisors will be used throughout the PPS. Using the AHRQ Working With Patient and Families as Advisors Implementation Handbook as a guide (http://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/strategy1/Strat1_Implement_Hndbook_508_v2.pdf) develop a training program for advisor roles in the PPS. | | | | | | | | | | |
| **Task** 6. Engage Medicaid members to participate as ad hoc advisors in the planning and development of programs, processes, and tools to transform healthcare delivery and address health disparities across cultures | | | | | | | | | | |
| **Task** 7. Using marketing avenues, brand developed strategies to drive toward goal of Triple Aim. | | | | | | | | | | |
| **Task** 8. Develop strategy, including policy / procedures, expectations, and guidelines for what, when, where, who and how outreach and navigation activities will be carried out. | | | | | | | | | | |
| **Task** 9. Implement outreach steps per strategy developed by PPS IDS | | | | | | | | | | |
| **Task** 10. Identify PPS partners for project and ensure those experienced with navigation, community health workers, and peer support is included. | | | | | | | | | | |
| **Task** 11. Create an inventory of community partners providing outreach and navigation activities (type, volume, role expectations, characteristics of individual and patient population served) | | | | | | | | | | |
| **Task** 12. Match characteristics of individual and patient population served with offered of services (ex. community-based organization, PCMH, clinical program). | | | | | | | | | | |
| **Task** 13. Community Health Workers (CHW). Using NY benchmarks as guide (http://nyshealthfoundation.org/uploads/resources/making-the-connection-community-health-workers-sept-2012.pdf), establish | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| roles expectations, selection process, standards, and onboarding curriculum to prepare Community Health Workers for positions in their own communities. Redeploy internal workers as possible. Include developed protocols for engagement. | | | | | | | | | | |
| **Task**<br>14. Establish a Self-Management Education Program (ex. Standard Self-Management Model) that is administered from the PPS level to increase capacity and flexibility of offerings. Choose a model that has been adapted to different cultures and may be taught in multiple languages. (Stanford Chronic Disease Self-Management model or similar program). | | | | | | | | | | |
| **Task**<br>15. Coordinate activities with patient activation measures in various projects across the PPS, with emphasis on 2di project alignment | | | | | | | | | | |
| **Task**<br>16. Based on the Community Needs Assessment, identify other populations that could benefit from the program in their native language using language interpretation platforms. | | | | | | | | | | |
| **Task**<br>17. Establish methods to stratify outcomes to quantify disparities, identify target areas and evaluate interventions. | | | | | | | | | | |

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Milestone #1**<br>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. | | | | | | | | | | |
| **Task**<br>PPS includes continuum of providers in IDS, including medical, behavioral health, post-acute, long-term care, and community-based providers. | | | | | | | | | | |
| **Task**<br>1. Complete full provider list of all AFBHC participants, including medical, behavioral, post-acute and long term care providers | | | | | | | | | | |
| **Task**<br>2. Assess and catalogue the PPS partners and stakeholder organizations clinical providers: physicians, physician's assistants, nurse practitioners, behavioral health providers, clinical psychologists, clinical social workers, Community based | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| service providers, social services and other MEB disorders care professionals.<br><br>Include: provider name, type, NPI, specialty, solo or group practice, practice size, number of open slots for new patients; PCMH status, presence and role of care coordination. | | | | | | | | | | |
| **Task**<br>3. Coordinate clinical assessments with assessment of IT capabilities (refer to Part I IT Systems and Processes and Population Health Management) to identify IT strengths and gaps. | | | | | | | | | | |
| **Task**<br>4. Building upon the description of the list of stakeholders and community engagement organizations presented in the DSRIP Project Plan application, conduct a drill-down assessment of the specific services provided by each stakeholder organization and how many clients/patients may be added to the their current case load with existing resources. | | | | | | | | | | |
| **Task**<br>5. Assess the Medicaid MCOs in the PPS service area, including CDPHP, MVP and Fidelis to engage in discussions regarding project-related issues and VBP. Evaluate MCO's Medicaid provider networks and compare and contrast to AFBHC network. Determine any follow up strategies depending on findings | | | | | | | | | | |
| **Task**<br>6. Project teams, Workforce leaders, and PPS administrative office staff will collaborate to conduct a network gap analysis and develop subsequent plan to fill gaps. Report findings to appropriate stakeholders including the Clinical Integration and Quality Committee | | | | | | | | | | |
| **Task**<br>7. Project future capacity needs per DSRIP project based on the patient and provider engagement timelines identify gaps or oversupply of the network. | | | | | | | | | | |
| **Task**<br>8. Develop a plan with timelines to meet those gaps based on the patient and provider engagement timelines | | | | | | | | | | |
| **Task**<br>9. Develop a dashboard of current capacity compared to projected capacity based on the patient and provider engagement timelines and distribute to pertinent internal stakeholders. | | | | | | | | | | |
| **Task**<br>10. Determine list of elements that need to be included in the provider agreements/contract and distribute and negotiate with | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| providers. | | | | | | | | | | |
| **Task** 11. Finalize participation agreements/contracts | | | | | | | | | | |
| **Task** 12. Create a process to track all executed provider agreements/contracts | | | | | | | | | | |
| **Task** 13. Create process and dashboard platform to track provider contracts, requirements, terms and corrective actions | | | | | | | | | | |
| **Task** 14. Report dashboards to the Governing Board on a quarterly basis for review, evaluation and action. | | | | | | | | | | |
| **Task** 15. Establish process for the periodic review of provider network lists to fill in the timely clinical and operational service gaps | | | | | | | | | | |
| **Milestone #2** Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS. | | | | | | | | | | |
| **Task** PPS produces a list of participating HHs and ACOs. | | | | | | | | | | |
| **Task** Participating HHs and ACOs demonstrate real service integration which incorporates a population management strategy towards evolving into an IDS. | | | | | | | | | | |
| **Task** Regularly scheduled formal meetings are held to develop collaborative care practices and integrated service delivery. | | | | | | | | | | |
| **Task** 1. Establish a planning process and re-occurring meetings with the AFBHC three partner Health Homes (Samaritan Hospital DBA Capital Region Health Connection; St Mary's HealthCare, Amsterdam, Visiting Nurse Service of Schenectady County, Inc. DBA Visiting Nurse Service of Northeastern New York) and IHANY ACO to develop a strategy that develops into an Integrated Delivery System. | | | | | | | | | | |
| **Task** 2. Conduct inventory of the population health management strategies and capabilities that have been adopted by the three partner Health Homes, the IHANY ACO, and compare capabilities to DSRIP requirements. | | | | | | | | | | |
| **Task** 3. Develop an ideal population health management model that leverages best practices from each entity. | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>4. As part of the Part I IT Systems and Processes plan, assess the population health management IT tools and systems used by the three Health Homes, seven key partners, IHANY and other partners throughout the PPS (refer to Part 1 IT Systems and Processes). Include: gaps in care Identification capabilities, risk stratification capability, patient outreach & engagement capability, patient care and tracking capability, patient to provider attribution capabilities. | | | | | | | | | | |
| **Task**<br>5. Coordinate strategy for Population Health IT tools and software with IHANY, Health Homes, and community providers (refer to Part I Clinical Integration). | | | | | | | | | | |
| **Milestone #3**<br>Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services. | | | | | | | | | | |
| **Task**<br>Clinically Interoperable System is in place for all participating providers. | | | | | | | | | | |
| **Task**<br>PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS. | | | | | | | | | | |
| **Task**<br>PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are followed. | | | | | | | | | | |
| **Task**<br>PPS trains staff on IDS protocols and processes. | | | | | | | | | | |
| **Task**<br>1. Create the AFBHC centralized Clinical Integration and Quality Department to coordinate and align care management across the PPS. | | | | | | | | | | |
| **Task**<br>2. Identify and document care management best practices from the Medicaid Health Homes, the Comprehensive Primary Care Initiative (CPCI) participants, and NCQA recognized PCMHs | | | | | | | | | | |
| **Task**<br>3. Incorporating best practices, document with a flow diagram the care management workflow / patient flow among the PPS partners and CBOs. | | | | | | | | | | |
| **Task**<br>4. Select the care transitions model(s) that will be endorsed by the PPS and define the transitions workflow / patient flow among | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| the PPS partners and CBOs, including discharges from SNFs. | | | | | | | | | | |
| **Task**<br>5. Formally adopt and operationalize the AFBHC Population Health Management Model that cares for people within a PCMH/behavioral/mental health foundation surrounded by a comprehensive integrated network inclusive of medical specialists, acute, post-acute, community based and social services. The model is inclusive of risk-stratification of populations with attendant prevention and wellness interventions with effective transitions and care coordination processes. The model is supported by robust technology, timely actionable analytics, and actuarially-sound payment models from managed care organizations. Conduct subsequent steps within the context of this model. | | | | | | | | | | |
| **Task**<br>6. Incorporating identified best practices, revise care management job descriptions to demonstrate the interrelated care management roles of the Health Homes, Home Care, downstream providers, acute inpatient care management, primary care, outpatient behavioral care, social services, public health organizations, state mental health agencies and care transitions programs | | | | | | | | | | |
| **Task**<br>7. Incorporate and implement revised care management roles in Projects 2.b.iii., 3.a.i., 3.a.iv., 3.d.ii., 3.g.i. and 4.a.iii. | | | | | | | | | | |
| **Task**<br>8. Implement selected care transitions model in Projects 2.b.iv. and 2.b.viii | | | | | | | | | | |
| **Milestone #4**<br>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. | | | | | | | | | | |
| **Task**<br>EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | 42 | 55 | 55 | 55 | 55 | 55 | 55 | 55 | 55 | 55 |
| **Task**<br>EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | 59 | 78 | 78 | 78 | 78 | 78 | 78 | 78 | 78 | 78 |
| **Task**<br>EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | 9 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task** EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | 33 | 43 | 43 | 43 | 43 | 43 | 43 | 43 | 43 | 43 |
| **Task** EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | 20 | 26 | 26 | 26 | 26 | 26 | 26 | 26 | 26 | 26 |
| **Task** PPS uses alerts and secure messaging functionality. | | | | | | | | | | |
| **Task** 1. Survey participating providers to understand current infrastructure and connectivity to HIXNY | | | | | | | | | | |
| **Task** 2. Determine requirements for HIXNY connectivity among partners. Assess current systems capability against these requirements. | | | | | | | | | | |
| **Task** 3. Create a gap analysis based on the current state analysis to determine incremental IT needs and associated budget, including short-term manual solutions. | | | | | | | | | | |
| **Task** 4. Develop a roll-out plan for systems to achieve sharing health information among clinical partners, including a training plan to support the successful implementation of new platforms and processes | | | | | | | | | | |
| **Task** 5. Establish a process for monitoring project milestones and performance | | | | | | | | | | |
| **Task** 6. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS | | | | | | | | | | |
| **Task** 7. Align Project implementation timelines with respective IT timeline to ensure IT requirements are in place for project implementation. | | | | | | | | | | |
| **Task** 8. Where EHR functionality is not yet ready, implement alternate in the interim. Track conversion to electronic systems. | | | | | | | | | | |
| **Task** 9. Coordinate with IT Systems and Processes for the roadmap to achieving clinical data sharing and interoperable systems across PPS network | | | | | | | | | | |
| **Task** 10. Collaborate with hospital systems and IT to assess and edit current policies and protocols around actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up | | | | | | | | | | |
| **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. | | | | | | | | | | |
| **Task** EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria). | | | | | | | | | | |
| **Task** PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM. | 37 | 55 | 55 | 55 | 55 | 55 | 55 | 55 | 55 | 55 |
| **Task** 1. Survey participating providers to understand their use of EHR's and PCMH status and level | | | | | | | | | | |
| **Task** 2. Determine requirements for meeting Meaningful Use and PCMH level 3 standards. Assess current systems capability against these requirements. | | | | | | | | | | |
| **Task** 3. Create a gap analysis based on the current state analysis to determine incremental needs and associated budget | | | | | | | | | | |
| **Task** 4. Develop a roll-out plan for systems to achieve Meaningful Use and PCMH level 3 certification, including a training plan to support the successful implementation of new platforms and processes. | | | | | | | | | | |
| **Task** 5. Establish a project management process and tool for monitoring project milestones and performance | | | | | | | | | | |
| **Task** 6. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS | | | | | | | | | | |
| **Task** 7. Track progress toward PCMH Level 3 recognition, including progress toward meaning use. | | | | | | | | | | |
| **Milestone #6** Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers. | | | | | | | | | | |
| **Task** PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| reporting. | | | | | | | | | | |
| **Task** 1. Define populations for which registries are needed based on current data available through portals such as Salient | | | | | | | | | | |
| **Task** 2. Survey Participating partners to determine requirements for population health strategy and requirements | | | | | | | | | | |
| **Task** 3. Create a gap analysis based on the current state analysis to determine incremental IT needs and associated budget, including short-term manual solutions | | | | | | | | | | |
| **Task** 4. Develop a roll-out plan for systems and IT platforms including patient registries among clinical partners, including a training plan to support the successful implementation of new platforms and processes | | | | | | | | | | |
| **Task** 5. Establish a process for monitoring project milestones and performance metrics | | | | | | | | | | |
| **Task** 6. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPs | | | | | | | | | | |
| **Task** 7. Where EHR functionality is not yet ready, implement alternate in the interim. Track conversion to electronic systems. | | | | | | | | | | |
| **Task** 8. Coordinate strategy for Population Health IT tools and software with IHANY (refer to Part I Clinical Integration) and the IT Roadmap (refer to Part I IT Systems and Processes). | | | | | | | | | | |
| **Milestone #7** Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3. | | | | | | | | | | |
| **Task** Primary care capacity increases improved access for patients seeking services - particularly in high-need areas. | | | | | | | | | | |
| **Task** All practices meet 2014 NCQA Level 3 PCMH and/or APCM standards. | 337 | 506 | 506 | 506 | 506 | 506 | 506 | 506 | 506 | 506 |
| **Task** EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| into the assessment criteria.) | | | | | | | | | | |
| **Task** 1. Designate a PPS level PCMH project lead | | | | | | | | | | |
| **Task** 2. Establish PCMH project team | | | | | | | | | | |
| **Task** 3. Finalize strategy for achieving PCMH Level 3 certification for contracted providers | | | | | | | | | | |
| **Task** 4. Classify providers according to criteria to their level of NCQA qualification: not recognized, Level 1, 2, and 3 using 2011 standards, and those that are in process of applying for 2014 standards. | | | | | | | | | | |
| **Task** 5. Classify providers according to criteria required to meet Meaningful Use Stage 2 requirements | | | | | | | | | | |
| **Task** 6. Based on analysis of pros/cons of corporate vs individual practice NCQA PCMH recognition, select approach(es) for provider groups | | | | | | | | | | |
| **Task** 7. Determine level of support with financial implications for AFBHC | | | | | | | | | | |
| **Task** 8. Assess level of administrative and financial support that MCO's in the region are currently providing or planning to provide primary care practices to help them achieve PCMH Level 2014 standards to ensure there is coordination and no duplication of effort. | | | | | | | | | | |
| **Task** 9. Collect NCQA recognition documentation from practices that are currently 2014 or 2011 Level 3 recognized | | | | | | | | | | |
| **Task** 10. PCMH project team to finalize roadmap for achieving Meaningful Use with providers | | | | | | | | | | |
| **Task** 11. Establish goals and timelines to achieve 2014 Level 3 NCQA recognition by the end of DY3. | | | | | | | | | | |
| **Task** 12. Identify practices participating in projects whose implementation success depends on them achieving 2014 recognition and target them to achieve recognition first. (2.b.iii, 2.b.iii, 3.a.i.) | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>13. Establish goals and timelines to achieve 2014 Level 3 NCQA recognition by the end of DY3, starting with practices currently in progress. | | | | | | | | | | |
| **Task**<br>14. Asses the practices' needs for technical assistance and provide technical assistance. | | | | | | | | | | |
| **Task**<br>15. Track providers progress on quarterly basis for meeting requirements within projected roadmap and take corrective action and or celebrate depending on results | | | | | | | | | | |
| **Milestone #8**<br>Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements. | | | | | | | | | | |
| **Task**<br>Medicaid Managed Care contract(s) are in place that include value-based payments. | | | | | | | | | | |
| **Task**<br>1. Establish the structure and process for MCO leadership, and representatives from the PPS Clinical Integration Committee, PPS Finance Committee, IHANY, PPS executives, and other stakeholders as needed to establish the plan for the development of a value-based payment strategy. (Refer to Part 1 Governance). | | | | | | | | | | |
| **Task**<br>2. Using the structure and process established, create value-based incentive arrangement models appropriate for the AFBHC and its partners. | | | | | | | | | | |
| **Task**<br>3. Research and evaluate different models of value-based payment arrangements referencing, including but not limited to: CMS-approved "A Path Toward Value Based Payment, New York State Roadmap for Medicaid Payment Reform" (June 2015). | | | | | | | | | | |
| **Milestone #9**<br>Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform. | | | | | | | | | | |
| **Task**<br>PPS holds monthly meetings with Medicaid Managed Care plans to evaluate utilization trends and performance issues and ensure payment reforms are instituted. | | | | | | | | | | |
| **Task**<br>1. Establish the structure and process to meet regularly with MCOs to review and evaluate costs, quality, and utilization | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>2. Define participants: MCOs, PPS / IHANY clinical integration committee, PPS finance committee, and other stakeholders as indicated | | | | | | | | | | |
| **Task**<br>3. Define monthly meeting schedule. | | | | | | | | | | |
| **Task**<br>4. Define data series of utilization and performance measures to track and Develop data reports | | | | | | | | | | |
| **Task**<br>5. Establish a process to provide feedback to selected governance or operational bodies on a regular basis to review data; resolve performance gaps; and report back progress | | | | | | | | | | |
| **Task**<br>6. Include the following issues identified in the projects: Including but not limited to: 2.a.i, 2.b.iv, 2.d.i, 3.a.iv, 3.d.2, 3.g.i, and 4.b.i | | | | | | | | | | |
| **Milestone #10**<br>Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes. | | | | | | | | | | |
| **Task**<br>PPS submitted a growth plan outlining the strategy to evolve provider compensation model to incentive-based compensation | | | | | | | | | | |
| **Task**<br>Providers receive incentive-based compensation consistent with DSRIP goals and objectives. | | | | | | | | | | |
| **Task**<br>1. Build infrastructure for collecting, reporting and ensuring the quality of provider performance data is available for performance tracking and subsequent incentive payments. | | | | | | | | | | |
| **Task**<br>2. Establish a process to identify and resolve documentation gaps that may affect performance reporting. | | | | | | | | | | |
| **Task**<br>3. Establish incentive compensation to patient outcomes consistent with DSRIP goals considering the budget and funds flow framework. | | | | | | | | | | |
| **Task**<br>4. Develop VBP Educational Program explaining the content and implications of Level 1, 2, and 3 Value Based Payments as it refers to: all care for total population, integrated primary care, acute and chronic bundles, and total care subpopulations: New York State Roadmap for Medicaid Payment Reform (June 2015). | | | | | | | | | | |
| **Task**<br>5. Establish communication schedule to present the VBP Educational Program | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>6. Model agreed-upon value-based payment arrangements that align incentives with outcomes, are actuarially sound, and are acceptable to the network and share findings with appropriate stakeholders, Finance Committee, and the Board | | | | | | | | | | |
| **Task**<br>7. Develop a plan that demonstrates how the incentive based payment model would evolve into value based payment model and obtain Board approval. | | | | | | | | | | |
| **Milestone #11**<br>Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate. | | | | | | | | | | |
| **Task**<br>Community health workers and community-based organizations utilized in IDS for outreach and navigation activities. | | | | | | | | | | |
| **Task**<br>1. Using input from IHANY, results from the community needs assessment, the AFBHC PPS will establish communication methods for providers, community health workers, clients, peers and community organizations outlining short term and long term goals of DSRIP. | | | | | | | | | | |
| **Task**<br>2. Based on Community Needs Assessment, identify chronic diseases that will have outreach programs offered (chronic disease in general, diabetes, end stage renal disease, chronic pain, cancer survivors). | | | | | | | | | | |
| **Task**<br>3. Determine strategy for apprising community assessment information, including determination of repeating assessment within the DSRIP calendar timeframe | | | | | | | | | | |
| **Task**<br>4. In conjunction with the workforce committee, determine training curriculum for community health workers, including train the trainer methods, learning management system modules, and other educational platforms | | | | | | | | | | |
| **Task**<br>5. Include Cultural Competency / Health Literacy committee to decide where and how advisors will be used throughout the PPS. Using the AHRQ Working With Patient and Families as Advisors Implementation Handbook as a guide (http://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/strategy1/Strat1_Implement_Hndbook_508_v2.pdf) develop a training program for advisor roles in the PPS. | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task** 6. Engage Medicaid members to participate as ad hoc advisors in the planning and development of programs, processes, and tools to transform healthcare delivery and address health disparities across cultures | | | | | | | | | | |
| **Task** 7. Using marketing avenues, brand developed strategies to drive toward goal of Triple Aim. | | | | | | | | | | |
| **Task** 8. Develop strategy, including policy / procedures, expectations, and guidelines for what, when, where, who and how outreach and navigation activities will be carried out. | | | | | | | | | | |
| **Task** 9. Implement outreach steps per strategy developed by PPS IDS | | | | | | | | | | |
| **Task** 10. Identify PPS partners for project and ensure those experienced with navigation, community health workers, and peer support is included. | | | | | | | | | | |
| **Task** 11. Create an inventory of community partners providing outreach and navigation activities (type, volume, role expectations, characteristics of individual and patient population served) | | | | | | | | | | |
| **Task** 12. Match characteristics of individual and patient population served with offered of services (ex. community-based organization, PCMH, clinical program). | | | | | | | | | | |
| **Task** 13. Community Health Workers (CHW). Using NY benchmarks as guide (http://nyshealthfoundation.org/uploads/resources/making-the-connection-community-health-workers-sept-2012.pdf), establish roles expectations, selection process, standards, and onboarding curriculum to prepare Community Health Workers for positions in their own communities. Redeploy internal workers as possible. Include developed protocols for engagement. | | | | | | | | | | |
| **Task** 14. Establish a Self-Management Education Program (ex. Standard Self-Management Model) that is administered from the PPS level to increase capacity and flexibility of offerings. Choose a model that has been adapted to different cultures and may be taught in multiple languages. (Stanford Chronic Disease Self-Management model or similar program). | | | | | | | | | | |
| **Task** 15. Coordinate activities with patient activation measures in | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| various projects across the PPS, with emphasis on 2di project alignment | | | | | | | | | | |
| **Task**<br>16. Based on the Community Needs Assessment, identify other populations that could benefit from the program in their native language using language interpretation platforms. | | | | | | | | | | |
| **Task**<br>17. Establish methods to stratify outcomes to quantify disparities, identify target areas and evaluate interventions. | | | | | | | | | | |

### Prescribed Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|

No Records Found

### Prescribed Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|
| 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. | Task 3 originally dated 12/31/2015 has been moved to 6/30/2016 to reflect the ongoing nature of the work. |
| Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS. | |
| Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services. | |
| 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. | |
| 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. | Tasks 2,3, and 4 originally dated 12/31/2015 have been moved to 06/30/2016 to reflect the ongoing nature of the work. |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Prescribed Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|
| Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers. | Tasks 1 and 2 originally dated 12/31/2015 have been moved to 9/30/2016. Tasks 3 and 4 originally dated 12/31/2015 have been moved to 12/31/2016. These changes reflect the ongoing nature of the work. |
| Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3. | Task 2 originally dated 12/31/2015 has been moved to 3/31/2016. Tasks 3, 4, 5, 6, 7, 8, 9, and 10 originally dated 12/31/2015 have been moved to 6/30/2016. These changes reflect the ongoing nature of the work. |
| Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements. | |
| Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform. | |
| Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes. | |
| Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate. | |

### Milestone Review Status

| Milestone # | Review Status | IA Formal Comments |
|---|---|---|
| **Milestone #1** | Pass & Ongoing | |
| **Milestone #2** | Pass & Ongoing | |
| **Milestone #3** | Pass & Ongoing | |
| **Milestone #4** | Pass & Ongoing | |
| **Milestone #5** | Pass & Ongoing | |
| **Milestone #6** | Pass & Ongoing | |
| **Milestone #7** | Pass & Ongoing | |
| **Milestone #8** | Pass & Ongoing | |
| **Milestone #9** | Pass & Ongoing | |
| **Milestone #10** | Pass & Ongoing | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Milestone Review Status

| Milestone # | Review Status | IA Formal Comments |
|---|---|---|
| **Milestone #11** | Pass & Ongoing | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 2.a.i.3 - PPS Defined Milestones

**Instructions :**

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for PPS-defined milestones.

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|

No Records Found

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC  (PPS ID:3)

### IPQR Module 2.a.i.4 - IA Monitoring

**Instructions :**

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Project 2.b.iii – ED care triage for at-risk populations

#### IPQR Module 2.b.iii.1 - Major Risks to Implementation and Mitigation Strategies

**Instructions :**

Please describe what the major risks are for this project, as well as the actions you plan to take to mitigate them.

One risk that threatens the success of this project is that the number of new patients referred to Primary Care Physicians (PCP) from the ED exceeds the PPS' primary care capacity to absorb new patients. To mitigate this risk, one of the first steps is to identify PCPs that are accepting new patients and ensure that processes are in place for ED navigators to refer patients to these targeted PCPs. To ensure primary care placement opportunities for patients, the PPS will track supply & demand for primary care throughout the PPS to identify gaps, assess geographic areas of need & recruit & place physicians in PCP shortage areas. Open access scheduling capabilities will also be assessed with current state PCP practices & a recommendation for future state participating practices. Demand for primary care from this project will be coordinated with Project 2.d.i. as industry experience has shown that as the number of insured increase, the need for primary care increases. Due to PCP shortages in the area and nationally, the PPS is also evaluating the need for primary care Nurse Practitioners and exploring with the Workforce Committee the retraining & redeployment of currently employed licensed nurses to pursue advanced practice credentials in primary care.

Another risk is that patients may not want to be redirected to PCPs. To mitigate this risk, the project will develop a patient education campaign, including patient focus groups, Medicaid beneficiaries & community representatives to include preventive health importance and continuity of care benefits.

There are multiple IT Risks, such as data interoperability dependent upon working with multiple vendors that may not support existing standards- the risk mitigation strategy is to engage vendors early & determine supplemental solutions where available. The RHIO, which is expected to be the interoperable clinical platform, has expressed limitations on data sharing per NY state policies, working with EHR vendors to achieve data sharing & balancing the needs of the DSRIP program with their existing commitments. The PPS will work closely with the RHIO. As Population Health IT (PHIT) systems and tools are required, any delay to PHIT implementation delays the projects & risks not meeting speed & scale requirements. As PHIT roll-out depends on sufficient capital funding from NY state, delay in the capital release will delay the rollout. The PPS will accelerate implementation of PHIT interoperability & tools, use alternate methods where EHRs & PHIT tool functionality aren't yet ready & work with NY to ensure capital is provided in sufficient time.

A risk to the PPS is that the successful implementation of this project will have negative impacts on the hospitals' finances. Since ED visits & inpatient admissions via the ED are sources of revenue for the hospitals, as patients become more engaged in appropriate outpatient venues, volume for the EDs & revenues for the hospitals will also decline. The mitigation strategy is to monitor hospital admissions/readmissions, revenues/sources of revenue; document the amount, timing & duration of the impact; & allocate funding in the budget & funds flow to offset revenue losses due to reduced hospital utilization.

Resistance to change is a risk common to DSRIP project interventions. For this project, the PPS has already been piloting navigators in the ED & has a project manager in place. Resistance will be mitigated by integrating requirements of the 2.b.iii. with the current navigator role & to closely

oversee the project with a dedicated project director responsible for implementation in the 6 emergency departments. Project 2.b.iii will work closely with the workforce strategy of AFBHC & the PPS, & assess the effectiveness of the navigator role based on patient & provider engagement speed and milestone achievement of the DSRIP timeline.

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 2.b.iii.2 - Patient Engagement Speed

**Instructions :**

Enter the number of patients actively engaged through the current quarter. The number entered into the "Patient Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for DY1 Q3 should include patients previously reported in DY1 Q2 plus new patients engaged in DY1 Q3. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

| Benchmarks | |
|---|---|
| **100% Actively Engaged By** | **Expected Patient Engagement** |
| DY3,Q4 | 33,970 |

| Patients Engaged to Date in Current DY | DY1,Q3 Patient Update | % of Semi-Annual Commitment To-Date | Semi-Annual Variance of Projected to Actual | % of Total Actively Engaged Patients To-Date |
|---|---|---|---|---|
| 409 | 409 | 2.50% | 15,943 | 1.20% |

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (16,352)

### Current File Uploads

| User ID | File Type | File Name | File Description | Upload Date |
|---|---|---|---|---|
| cdomeier | Communication Documentation | 3_PMDL2715_1_3_20160129155413_DY1Q3_absense_of_patient_registry_explanation.docx | Explanation for absence of DY1, Q3 Patient Update | 01/29/2016 03:55 PM |

**Narrative Text :**

For PPS to provide additional context regarding progress and/or updates to IA.

### Module Review Status

| Review Status | IA Formal Comments |
|---|---|
| Fail | The PPS failed to meet at least 80% of its actively engaged commitments for DY1Q3. The documentation does not support the reported actively engaged numbers. |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 2.b.iii.3 - Prescribed Milestones

**Instructions :**

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for prescribed milestones. For milestones that are due and completed within the reporting period, documentation is required to provide evidence of project requirement achievement. Any explanations regarding altered or missed provider commitments should be included within the narrative box, not as text within uploaded documentation.

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| **Milestone #1** Establish ED care triage program for at-risk populations | Project | N/A | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** Stand up program based on project requirements | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 1. Identify project lead at PPS level | Project | | Completed | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 |
| **Task** 2. The following six Emergency Departments (EDs) will participate in the project: St Mary's Hospital, Amsterdam; Ellis Hospital; St Peter's Hospital ; Samaritan Hospital, St Mary's Hospital, Troy; and Albany Memorial Hospital. Incremental establishment of the ED Navigator roll out plan will be devised with ED leadership.<br>• Hospital – ED and Behavioral Health leadership teams are formulating an urgent care business plan to redirect non-emergent behavioral health & medical (60/40) ED visits to a secondary Ellis site location. This will allow ESI Levels 4 & 5 to be treated and released with follow up and lessen high volumes and throughput congestion of main ED campus. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 3. Identify and invite key stakeholders to project teams, such as EMS, law enforcement, transportation, housing, community services and public organizations and practitioners. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 4. Pilot program at St Mary's Hospital ED for initial roll out of project and stage implementation of other EDs | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 5. Form project implementation teams at each site, including ED administrative and front line staff and PPS providers | Project | | In Progress | 08/01/2015 | 03/31/2018 | 08/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** | Project | | In Progress | 08/01/2015 | 03/31/2018 | 08/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| 6. Conduct monthly meetings with project lead and teams from sites, define roles and responsibility and track progress toward objectives of program. Include additional stakeholder meetings to address workforce and recruitment efforts to meet associated staffing needs of the project. | | | | | | | | | |
| **Task**<br>7. Identify process metrics, institute tracking mechanism to collect data, manually then progression to IT platform | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>8. Define future state for ED patient navigator model to include a social triage of At-Risk define populations to assess for: PCP needs or connectivity, transportation barriers/needs, medication attainment, health home care management services, home care services, community meals, DME equipment needs, etc. Assessment and attainment of services will assist member to follow up in the most cost effective setting and be provided with the help they need to maintain their health and wellbeing. | Project | | In Progress | 08/01/2015 | 03/31/2018 | 08/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>9. Define target, at-risk patient population. PPS will consider ED visits with an ESI triage level of 4 or 5, as well as, At-Risk populations identified in our Community Needs Assessment. | Project | | In Progress | 08/01/2015 | 03/31/2018 | 08/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>10. Identify and communicate with project teams baseline metrics and potentially preventable ED visit salient data results | Project | | In Progress | 08/01/2015 | 03/31/2018 | 08/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>11. Add PCMH staff to project teams to coordinate open access scheduling and other PCMH requirements of project | Project | | In Progress | 11/01/2015 | 03/31/2018 | 11/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>12. Track and evaluate programs at each site using rapid cycle team evaluation techniques | Project | | In Progress | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>13. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | Project | | In Progress | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Milestone #2**<br>Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling.<br>a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS | Project | N/A | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |

# New York State Department Of Health
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## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| Advanced Primary Care Model standards by the end of DSRIP Year 3.<br>b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers.<br>c. Ensure real time notification to a Health Home care manager as applicable | | | | | | | | | |
| **Task**<br>All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards. | Provider | Safety Net Practitioner - Primary Care Provider (PCP) | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.) | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>Encounter Notification Service (ENS) is installed in all PCP offices and EDs | Provider | Safety Net Practitioner - Primary Care Provider (PCP) | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>Encounter Notification Service (ENS) is installed in all PCP offices and EDs | Provider | Safety Net Hospital | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>1. Work with PPS project team to identify Contract/MOUs with PCP practices | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>2. Classify providers according to criteria required to meet Meaningful Use Stage 2 requirements. | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task**<br>3. Classify providers according to criteria to their level of NCQA qualification: not recognized, Level 1, 2, and 3 using 2011 standards, and those that are in process of applying for 2014 standards. | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task**<br>4. Establish communication means for encounter notification systems through various avenues, including direct communication, IT solutions and other notification systems for PCPs | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>5. Establish communication means for encounter notification | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| systems (ENS) through various avenues, including direct communication, IT solutions and other notification systems for Health Home care managers | | | | | | | | | |
| **Task** 6. Track progress toward completion of fully functioning ENS in PCP offices and Health Home lead agencies. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 7. Track providers progress on quarterly basis for meeting requirements within projected roadmap | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 8. Finalize strategy for achieving PCMH Level 3 certification for contracted providers | Project | | In Progress | 09/01/2015 | 12/31/2015 | 09/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task** 9. Assess level of administrative and financial support that MCO's in the region are currently providing or planning to provide primary care practices to help them achieve PCMH Level 2014 standards to ensure there is coordination and no duplication of effort. | Project | | In Progress | 09/01/2015 | 12/31/2015 | 09/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task** 10. PCMH project team to finalize roadmap for achieving Meaningful Use with providers | Project | | In Progress | 09/01/2015 | 12/31/2015 | 09/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task** 11. Identify PCMH practices that have flexible scheduling/open access scheduling currently in place | Project | | In Progress | 09/01/2015 | 03/31/2018 | 09/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 12. On a quarterly basis, update master census of PCMH providers and level achieved that is distribute to patient navigators at rolled out sites. See Milestone #5 | Project | | In Progress | 09/01/2015 | 03/31/2018 | 09/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Milestone #3** For patients presenting with minor illnesses who do not have a primary care provider:<br>a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need.<br>b. Patient navigator will assist the patient with identifying and accessing needed community support resources.<br>c. Patient navigator will assist the member in receiving a timely | Project | N/A | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |

# New York State Department Of Health
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## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| appointment with that provider's office (for patients with a primary care provider). | | | | | | | | | |
| **Task**<br>A defined process for triage of patients from patient navigators to non-emergency PCP and needed community support resources is in place. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>1. Assess current state ED triage flow for target, at-risk populations as defined in Requirement #1, step #8 | Project | | Completed | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 |
| **Task**<br>2. Consider scope of roles and responsibilities of patient navigator, such as:<br>• Evaluate (in person or follow up next day) of all ED Visits by Medicaid Members meeting level 4 or 5<br>• Assess with member to arrange for a post ED follow up PCP visit or re-connectively to their exiting PCP.<br>• Assess transportation needs/barriers. Connect member with Medicaid Answering Services for covered health care appointments<br>• Assess medication attainment barriers. If no means of transportation, assess for scheduled home delivery of medications or contract with local transportation companies to assist members with Pharmacy trip to fill scripts.<br>• Assess additional needs to be referred to Health Home Care Managed Service, or if already involved, message Health Home CM with ED alert notice of their member<br>• Assess for additional community needs such as meals on wheels, DME equipment needs, home health services, etc and referral to community based organization as indicated | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task**<br>3. Design patient navigator workflow with key stakeholders that will need support staff to sustain project requirements (Hospital Directors of Care Management Departments, ED Management, Health Home Management) | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task**<br>4. Develop process and protocols for navigator interactions for ESI level 4 and 5 triaged patients | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| **Task** 5. Determine per ED location/volume hours of navigator operation to meet project requirements | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 6. Select, hire, retrain, redeploy navigators per site implementation | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 7. Identify method to flag target patient population to patient navigator | Project | | In Progress | 09/01/2015 | 03/31/2018 | 09/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 8. Design scripting to be used by navigator staff when interfacing with target population | Project | | In Progress | 09/01/2015 | 12/31/2016 | 09/01/2015 | 12/31/2016 | 12/31/2016 | DY2 Q3 |
| **Task** 9. Maintain current listing of all community support resources that will be used to connect target patients to appropriate services | Project | | In Progress | 09/01/2015 | 12/31/2016 | 09/01/2015 | 12/31/2016 | 12/31/2016 | DY2 Q3 |
| **Task** 10. Develop process for patient navigator to hand off pertinent information to PCP/care manager/health home care manager, care transitions coach and other CBO services currently involved | Project | | In Progress | 09/01/2015 | 12/31/2015 | 09/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task** 11. Develop scripting guidance for patient preference on scheduling appointment, locations, barriers to keeping appointment, transportation | Project | | In Progress | 09/01/2015 | 12/31/2015 | 09/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task** 12. Include methods to address age appropriate literacy level and adapt methods accordingly | Project | | In Progress | 09/01/2015 | 12/31/2017 | 09/01/2015 | 12/31/2017 | 12/31/2017 | DY3 Q3 |
| **Task** 13. When process for Project 2di implemented, train patient navigators in PAM tool to use for capture special patient population | Project | | In Progress | 07/01/2015 | 12/31/2016 | 07/01/2015 | 12/31/2016 | 12/31/2016 | DY2 Q3 |
| **Task** 14. Integrate project plan components with PPS projects that influence outcomes and collaborate with surrounding communities and other PPS as necessary | Project | | In Progress | 09/01/2015 | 03/31/2018 | 09/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 15. Inform PCPs, behavioral health providers and CBOs, including but not limited to EMS and law enforcement organizations implementation of patient navigator program and | Project | | In Progress | 11/01/2015 | 03/31/2017 | 11/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| track education sessions | | | | | | | | | |
| **Task** 16. Within the requirements of EMTALA and other regulatory policies, explore the possibilities to use EMS as the remote arms and eyes for ED providers to guide interventions in the field and to minimize ED over-utilization of non-emergent episodes | Project | | In Progress | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 17. Invite local transportation units and EMS to submit plans for pilot programs for innovative system change, implement if appropriate | Project | | In Progress | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 18. Explore transportation options to increase adherence to medication attainment after discharge from ED to prevent recidivism. Engage pharmacological associations to develop innovated strategies to reduce barriers in attainment, medication reconciliation, poly-pharmacy and adherence to prescribed treatment regimen. | Project | | In Progress | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Milestone #4** Established protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.) | Project | N/A | On Hold | 04/01/2015 | 03/31/2020 | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** PPS has protocols and operations in place to transport non-acute patients to appropriate care site. (Optional). | Provider | Safety Net Hospital | On Hold | 04/01/2015 | 03/31/2020 | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #5** Use EHRs and other technical platforms to track all patients engaged in the project. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 1. Determine requirements for identification of targeted patients and tracking actively engaged patients per state-provided specifications for the DSRIP program. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 2. Review strategies and tools needed to promote DSRIP specific Patient Engagement for ED Triage project | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| **Task** 3. Working with the project committee document current and future state work flow of ED Triage project in addition to capturing manual solutions in place at this time. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 4. Assess current EHR and other technical platforms in the PPS against established requirements for patient identification and tracking, system notification, and treatment plan creation | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 5. Create a gap analysis based on the work flow analysis to determine incremental IT needs and associated budget, including short-term manual solutions | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 6. Identify prioritization of systems to build, metrics, or associated change with separate work streams focused on implementing new Electronic Health Record Systems vs. RHIO connectivity based on the DSRIP project needs and associated providers' needs | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 7. Develop a roll-out plan for systems to achieve clinical data sharing and associated metrics, including a training plan to support the successful implementation of new platforms and processes | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 8. Establish a process for monitoring project milestones and performance. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 9. Where electronic functionality is not yet ready, implement alternate in the interim and track conversion to electronic systems. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 10. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 11. Develop a process for determining how success will be measured that incorporates feedback from practitioners and other key users of IT, including financial and patient engagement impact and risks. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Milestone #1**<br>Establish ED care triage program for at-risk populations | | | | | | | | | | |
| **Task**<br>Stand up program based on project requirements | | | | | | | | | | |
| **Task**<br>1. Identify project lead at PPS level | | | | | | | | | | |
| **Task**<br>2. The following six Emergency Departments (EDs) will participate in the project: St Mary's Hospital, Amsterdam; Ellis Hospital; St Peter's Hospital ; Samaritan Hospital, St Mary's Hospital, Troy; and Albany Memorial Hospital. Incremental establishment of the ED Navigator roll out plan will be devised with ED leadership.<br>• Hospital – ED and Behavioral Health leadership teams are formulating an urgent care business plan to redirect non-emergent behavioral health & medical (60/40) ED visits to a secondary Ellis site location. This will allow ESI Levels 4 & 5 to be treated and released with follow up and lessen high volumes and throughput congestion of main ED campus. | | | | | | | | | | |
| **Task**<br>3. Identify and invite key stakeholders to project teams, such as EMS, law enforcement, transportation, housing, community services and public organizations and practitioners. | | | | | | | | | | |
| **Task**<br>4. Pilot program at St Mary's Hospital ED for initial roll out of project and stage implementation of other EDs | | | | | | | | | | |
| **Task**<br>5. Form project implementation teams at each site, including ED administrative and front line staff and PPS providers | | | | | | | | | | |
| **Task**<br>6. Conduct monthly meetings with project lead and teams from sites, define roles and responsibility and track progress toward objectives of program. Include additional stakeholder meetings to address workforce and recruitment efforts to meet associated staffing needs of the project. | | | | | | | | | | |
| **Task**<br>7. Identify process metrics, institute tracking mechanism to collect data, manually then progression to IT platform | | | | | | | | | | |
| **Task**<br>8. Define future state for ED patient navigator model to include a social triage of At-Risk define populations to assess for: PCP needs or connectivity, transportation barriers/needs, medication attainment, health home care management services, home care services, community meals, DME equipment needs, etc. | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| Assessment and attainment of services will assist member to follow up in the most cost effective setting and be provided with the help they need to maintain their health and wellbeing. | | | | | | | | | | |
| **Task**<br>9. Define target, at-risk patient population. PPS will consider ED visits with an ESI triage level of 4 or 5, as well as, At-Risk populations identified in our Community Needs Assessment. | | | | | | | | | | |
| **Task**<br>10. Identify and communicate with project teams baseline metrics and potentially preventable ED visit salient data results | | | | | | | | | | |
| **Task**<br>11. Add PCMH staff to project teams to coordinate open access scheduling and other PCMH requirements of project | | | | | | | | | | |
| **Task**<br>12. Track and evaluate programs at each site using rapid cycle team evaluation techniques | | | | | | | | | | |
| **Task**<br>13. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | | | | | | | | | | |
| **Milestone #2**<br>Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling.<br>a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3.<br>b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers.<br>c. Ensure real time notification to a Health Home care manager as applicable | | | | | | | | | | |
| **Task**<br>All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 9 | 21 |
| **Task**<br>EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.) | | | | | | | | | | |
| **Task**<br>Encounter Notification Service (ENS) is installed in all PCP offices and EDs | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 9 | 21 |
| **Task**<br>Encounter Notification Service (ENS) is installed in all PCP offices and EDs | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 5 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task** 1. Work with PPS project team to identify Contract/MOUs with PCP practices | | | | | | | | | | |
| **Task** 2. Classify providers according to criteria required to meet Meaningful Use Stage 2 requirements. | | | | | | | | | | |
| **Task** 3. Classify providers according to criteria to their level of NCQA qualification: not recognized, Level 1, 2, and 3 using 2011 standards, and those that are in process of applying for 2014 standards. | | | | | | | | | | |
| **Task** 4. Establish communication means for encounter notification systems through various avenues, including direct communication, IT solutions and other notification systems for PCPs | | | | | | | | | | |
| **Task** 5. Establish communication means for encounter notification systems (ENS) through various avenues, including direct communication, IT solutions and other notification systems for Health Home care managers | | | | | | | | | | |
| **Task** 6. Track progress toward completion of fully functioning ENS in PCP offices and Health Home lead agencies. | | | | | | | | | | |
| **Task** 7. Track providers progress on quarterly basis for meeting requirements within projected roadmap | | | | | | | | | | |
| **Task** 8. Finalize strategy for achieving PCMH Level 3 certification for contracted providers | | | | | | | | | | |
| **Task** 9. Assess level of administrative and financial support that MCO's in the region are currently providing or planning to provide primary care practices to help them achieve PCMH Level 2014 standards to ensure there is coordination and no duplication of effort. | | | | | | | | | | |
| **Task** 10. PCMH project team to finalize roadmap for achieving Meaningful Use with providers | | | | | | | | | | |
| **Task** 11. Identify PCMH practices that have flexible scheduling/open access scheduling currently in place | | | | | | | | | | |
| **Task** 12. On a quarterly basis, update master census of PCMH providers and level achieved that is distribute to patient | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| navigators at rolled out sites. See Milestone #5 | | | | | | | | | | |
| **Milestone #3**<br>For patients presenting with minor illnesses who do not have a primary care provider:<br>a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need.<br>b. Patient navigator will assist the patient with identifying and accessing needed community support resources.<br>c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider). | | | | | | | | | | |
| **Task**<br>A defined process for triage of patients from patient navigators to non-emergency PCP and needed community support resources is in place. | | | | | | | | | | |
| **Task**<br>1. Assess current state ED triage flow for target, at-risk populations as defined in Requirement #1, step #8 | | | | | | | | | | |
| **Task**<br>2. Consider scope of roles and responsibilities of patient navigator, such as:<br>• Evaluate (in person or follow up next day) of all ED Visits by Medicaid Members meeting level 4 or 5<br>• Assess with member to arrange for a post ED follow up PCP visit or re-connectively to their exiting PCP.<br>• Assess transportation needs/barriers. Connect member with Medicaid Answering Services for covered health care appointments<br>• Assess medication attainment barriers. If no means of transportation, assess for scheduled home delivery of medications or contract with local transportation companies to assist members with Pharmacy trip to fill scripts.<br>• Assess additional needs to be referred to Health Home Care Managed Service, or if already involved, message Health Home CM with ED alert notice of their member<br>• Assess for additional community needs such as meals on wheels, DME equipment needs, home health services, etc and referral to community based organization as indicated | | | | | | | | | | |
| **Task**<br>3. Design patient navigator workflow with key stakeholders that will need support staff to sustain project requirements (Hospital | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| Directors of Care Management Departments, ED Management, Health Home Management) | | | | | | | | | | |
| **Task** 4. Develop process and protocols for navigator interactions for ESI level 4 and 5 triaged patients | | | | | | | | | | |
| **Task** 5. Determine per ED location/volume hours of navigator operation to meet project requirements | | | | | | | | | | |
| **Task** 6. Select, hire, retrain, redeploy navigators per site implementation | | | | | | | | | | |
| **Task** 7. Identify method to flag target patient population to patient navigator | | | | | | | | | | |
| **Task** 8. Design scripting to be used by navigator staff when interfacing with target population | | | | | | | | | | |
| **Task** 9. Maintain current listing of all community support resources that will be used to connect target patients to appropriate services | | | | | | | | | | |
| **Task** 10. Develop process for patient navigator to hand off pertinent information to PCP/care manager/health home care manager, care transitions coach and other CBO services currently involved | | | | | | | | | | |
| **Task** 11. Develop scripting guidance for patient preference on scheduling appointment, locations, barriers to keeping appointment, transportation | | | | | | | | | | |
| **Task** 12. Include methods to address age appropriate literacy level and adapt methods accordingly | | | | | | | | | | |
| **Task** 13. When process for Project 2di implemented, train patient navigators in PAM tool to use for capture special patient population | | | | | | | | | | |
| **Task** 14. Integrate project plan components with PPS projects that influence outcomes and collaborate with surrounding communities and other PPS as necessary | | | | | | | | | | |
| **Task** 15. Inform PCPs, behavioral health providers and CBOs, including but not limited to EMS and law enforcement organizations implementation of patient navigator program and track education sessions | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>16. Within the requirements of EMTALA and other regulatory policies, explore the possibilities to use EMS as the remote arms and eyes for ED providers to guide interventions in the field and to minimize ED over-utilization of non-emergent episodes | | | | | | | | | | |
| **Task**<br>17. Invite local transportation units and EMS to submit plans for pilot programs for innovative system change, implement if appropriate | | | | | | | | | | |
| **Task**<br>18. Explore transportation options to increase adherence to medication attainment after discharge from ED to prevent recidivism. Engage pharmacological associations to develop innovated strategies to reduce barriers in attainment, medication reconciliation, poly-pharmacy and adherence to prescribed treatment regimen. | | | | | | | | | | |
| **Milestone #4**<br>Established protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.) | | | | | | | | | | |
| **Task**<br>PPS has protocols and operations in place to transport non-acute patients to appropriate care site. (Optional). | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Milestone #5**<br>Use EHRs and other technical platforms to track all patients engaged in the project. | | | | | | | | | | |
| **Task**<br>PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. | | | | | | | | | | |
| **Task**<br>1. Determine requirements for identification of targeted patients and tracking actively engaged patients per state-provided specifications for the DSRIP program. | | | | | | | | | | |
| **Task**<br>2. Review strategies and tools needed to promote DSRIP specific Patient Engagement for ED Triage project | | | | | | | | | | |
| **Task**<br>3. Working with the project committee document current and future state work flow of ED Triage project in addition to capturing manual solutions in place at this time. | | | | | | | | | | |
| **Task**<br>4. Assess current EHR and other technical platforms in the PPS against established requirements for patient identification and | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| tracking, system notification, and treatment plan creation | | | | | | | | | | |
| **Task** 5. Create a gap analysis based on the work flow analysis to determine incremental IT needs and associated budget, including short-term manual solutions | | | | | | | | | | |
| **Task** 6. Identify prioritization of systems to build, metrics, or associated change with separate work streams focused on implementing new Electronic Health Record Systems vs. RHIO connectivity based on the DSRIP project needs and associated providers' needs | | | | | | | | | | |
| **Task** 7. Develop a roll-out plan for systems to achieve clinical data sharing and associated metrics, including a training plan to support the successful implementation of new platforms and processes | | | | | | | | | | |
| **Task** 8. Establish a process for monitoring project milestones and performance. | | | | | | | | | | |
| **Task** 9. Where electronic functionality is not yet ready, implement alternate in the interim and track conversion to electronic systems. | | | | | | | | | | |
| **Task** 10. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS | | | | | | | | | | |
| **Task** 11. Develop a process for determining how success will be measured that incorporates feedback from practitioners and other key users of IT, including financial and patient engagement impact and risks. | | | | | | | | | | |

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Milestone #1** Establish ED care triage program for at-risk populations | | | | | | | | | | |
| **Task** Stand up program based on project requirements | | | | | | | | | | |
| **Task** 1. Identify project lead at PPS level | | | | | | | | | | |
| **Task** 2. The following six Emergency Departments (EDs) will participate in the project: St Mary's Hospital, Amsterdam; Ellis | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| Hospital; St Peter's Hospital ; Samaritan Hospital, St Mary's Hospital, Troy; and Albany Memorial Hospital. Incremental establishment of the ED Navigator roll out plan will be devised with ED leadership.<br>• Hospital – ED and Behavioral Health leadership teams are formulating an urgent care business plan to redirect non-emergent behavioral health & medical (60/40) ED visits to a secondary Ellis site location. This will allow ESI Levels 4 & 5 to be treated and released with follow up and lessen high volumes and throughput congestion of main ED campus. | | | | | | | | | | |
| **Task**<br>3. Identify and invite key stakeholders to project teams, such as EMS, law enforcement, transportation, housing, community services and public organizations and practitioners. | | | | | | | | | | |
| **Task**<br>4. Pilot program at St Mary's Hospital ED for initial roll out of project and stage implementation of other EDs | | | | | | | | | | |
| **Task**<br>5. Form project implementation teams at each site, including ED administrative and front line staff and PPS providers | | | | | | | | | | |
| **Task**<br>6. Conduct monthly meetings with project lead and teams from sites, define roles and responsibility and track progress toward objectives of program. Include additional stakeholder meetings to address workforce and recruitment efforts to meet associated staffing needs of the project. | | | | | | | | | | |
| **Task**<br>7. Identify process metrics, institute tracking mechanism to collect data, manually then progression to IT platform | | | | | | | | | | |
| **Task**<br>8. Define future state for ED patient navigator model to include a social triage of At-Risk define populations to assess for: PCP needs or connectivity, transportation barriers/needs, medication attainment, health home care management services, home care services, community meals, DME equipment needs, etc. Assessment and attainment of services will assist member to follow up in the most cost effective setting and be provided with the help they need to maintain their health and wellbeing. | | | | | | | | | | |
| **Task**<br>9. Define target, at-risk patient population. PPS will consider ED visits with an ESI triage level of 4 or 5, as well as, At-Risk populations identified in our Community Needs Assessment. | | | | | | | | | | |
| **Task**<br>10. Identify and communicate with project teams baseline metrics | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| and potentially preventable ED visit salient data results | | | | | | | | | | |
| **Task**<br>11. Add PCMH staff to project teams to coordinate open access scheduling and other PCMH requirements of project | | | | | | | | | | |
| **Task**<br>12. Track and evaluate programs at each site using rapid cycle team evaluation techniques | | | | | | | | | | |
| **Task**<br>13. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | | | | | | | | | | |
| **Milestone #2**<br>Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling.<br>a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3.<br>b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers.<br>c. Ensure real time notification to a Health Home care manager as applicable | | | | | | | | | | |
| **Task**<br>All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards. | 37 | 55 | 55 | 55 | 55 | 55 | 55 | 55 | 55 | 55 |
| **Task**<br>EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.) | | | | | | | | | | |
| **Task**<br>Encounter Notification Service (ENS) is installed in all PCP offices and EDs | 37 | 55 | 55 | 55 | 55 | 55 | 55 | 55 | 55 | 55 |
| **Task**<br>Encounter Notification Service (ENS) is installed in all PCP offices and EDs | 8 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 |
| **Task**<br>1. Work with PPS project team to identify Contract/MOUs with PCP practices | | | | | | | | | | |
| **Task**<br>2. Classify providers according to criteria required to meet Meaningful Use Stage 2 requirements. | | | | | | | | | | |
| **Task**<br>3. Classify providers according to criteria to their level of NCQA qualification: not recognized, Level 1, 2, and 3 using 2011 | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| standards, and those that are in process of applying for 2014 standards. | | | | | | | | | | |
| **Task**<br>4. Establish communication means for encounter notification systems through various avenues, including direct communication, IT solutions and other notification systems for PCPs | | | | | | | | | | |
| **Task**<br>5. Establish communication means for encounter notification systems (ENS) through various avenues, including direct communication, IT solutions and other notification systems for Health Home care managers | | | | | | | | | | |
| **Task**<br>6. Track progress toward completion of fully functioning ENS in PCP offices and Health Home lead agencies. | | | | | | | | | | |
| **Task**<br>7. Track providers progress on quarterly basis for meeting requirements within projected roadmap | | | | | | | | | | |
| **Task**<br>8. Finalize strategy for achieving PCMH Level 3 certification for contracted providers | | | | | | | | | | |
| **Task**<br>9. Assess level of administrative and financial support that MCO's in the region are currently providing or planning to provide primary care practices to help them achieve PCMH Level 2014 standards to ensure there is coordination and no duplication of effort. | | | | | | | | | | |
| **Task**<br>10. PCMH project team to finalize roadmap for achieving Meaningful Use with providers | | | | | | | | | | |
| **Task**<br>11. Identify PCMH practices that have flexible scheduling/open access scheduling currently in place | | | | | | | | | | |
| **Task**<br>12. On a quarterly basis, update master census of PCMH providers and level achieved that is distribute to patient navigators at rolled out sites. See Milestone #5 | | | | | | | | | | |
| **Milestone #3**<br>For patients presenting with minor illnesses who do not have a primary care provider:<br>a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need.<br>b. Patient navigator will assist the patient with identifying and | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| accessing needed community support resources.<br>c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider). | | | | | | | | | | |
| **Task**<br>A defined process for triage of patients from patient navigators to non-emergency PCP and needed community support resources is in place. | | | | | | | | | | |
| **Task**<br>1. Assess current state ED triage flow for target, at-risk populations as defined in Requirement #1, step #8 | | | | | | | | | | |
| **Task**<br>2. Consider scope of roles and responsibilities of patient navigator, such as:<br>• Evaluate (in person or follow up next day) of all ED Visits by Medicaid Members meeting level 4 or 5<br>• Assess with member to arrange for a post ED follow up PCP visit or re-connectively to their exiting PCP.<br>• Assess transportation needs/barriers. Connect member with Medicaid Answering Services for covered health care appointments<br>• Assess medication attainment barriers. If no means of transportation, assess for scheduled home delivery of medications or contract with local transportation companies to assist members with Pharmacy trip to fill scripts.<br>• Assess additional needs to be referred to Health Home Care Managed Service, or if already involved, message Health Home CM with ED alert notice of their member<br>• Assess for additional community needs such as meals on wheels, DME equipment needs, home health services, etc and referral to community based organization as indicated | | | | | | | | | | |
| **Task**<br>3. Design patient navigator workflow with key stakeholders that will need support staff to sustain project requirements (Hospital Directors of Care Management Departments, ED Management, Health Home Management) | | | | | | | | | | |
| **Task**<br>4. Develop process and protocols for navigator interactions for ESI level 4 and 5 triaged patients | | | | | | | | | | |
| **Task**<br>5. Determine per ED location/volume hours of navigator operation to meet project requirements | | | | | | | | | | |
| **Task**<br>6. Select, hire, retrain, redeploy navigators per site | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| implementation | | | | | | | | | | |
| **Task** 7. Identify method to flag target patient population to patient navigator | | | | | | | | | | |
| **Task** 8. Design scripting to be used by navigator staff when interfacing with target population | | | | | | | | | | |
| **Task** 9. Maintain current listing of all community support resources that will be used to connect target patients to appropriate services | | | | | | | | | | |
| **Task** 10. Develop process for patient navigator to hand off pertinent information to PCP/care manager/health home care manager, care transitions coach and other CBO services currently involved | | | | | | | | | | |
| **Task** 11. Develop scripting guidance for patient preference on scheduling appointment, locations, barriers to keeping appointment, transportation | | | | | | | | | | |
| **Task** 12. Include methods to address age appropriate literacy level and adapt methods accordingly | | | | | | | | | | |
| **Task** 13. When process for Project 2di implemented, train patient navigators in PAM tool to use for capture special patient population | | | | | | | | | | |
| **Task** 14. Integrate project plan components with PPS projects that influence outcomes and collaborate with surrounding communities and other PPS as necessary | | | | | | | | | | |
| **Task** 15. Inform PCPs, behavioral health providers and CBOs, including but not limited to EMS and law enforcement organizations implementation of patient navigator program and track education sessions | | | | | | | | | | |
| **Task** 16. Within the requirements of EMTALA and other regulatory policies, explore the possibilities to use EMS as the remote arms and eyes for ED providers to guide interventions in the field and to minimize ED over-utilization of non-emergent episodes | | | | | | | | | | |
| **Task** 17. Invite local transportation units and EMS to submit plans for pilot programs for innovative system change, implement if appropriate | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>18. Explore transportation options to increase adherence to medication attainment after discharge from ED to prevent recidivism. Engage pharmacological associations to develop innovated strategies to reduce barriers in attainment, medication reconciliation, poly-pharmacy and adherence to prescribed treatment regimen. | | | | | | | | | | |
| **Milestone #4**<br>Established protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.) | | | | | | | | | | |
| **Task**<br>PPS has protocols and operations in place to transport non-acute patients to appropriate care site. (Optional). | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Milestone #5**<br>Use EHRs and other technical platforms to track all patients engaged in the project. | | | | | | | | | | |
| **Task**<br>PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. | | | | | | | | | | |
| **Task**<br>1. Determine requirements for identification of targeted patients and tracking actively engaged patients per state-provided specifications for the DSRIP program. | | | | | | | | | | |
| **Task**<br>2. Review strategies and tools needed to promote DSRIP specific Patient Engagement for ED Triage project | | | | | | | | | | |
| **Task**<br>3. Working with the project committee document current and future state work flow of ED Triage project in addition to capturing manual solutions in place at this time. | | | | | | | | | | |
| **Task**<br>4. Assess current EHR and other technical platforms in the PPS against established requirements for patient identification and tracking, system notification, and treatment plan creation | | | | | | | | | | |
| **Task**<br>5. Create a gap analysis based on the work flow analysis to determine incremental IT needs and associated budget, including short-term manual solutions | | | | | | | | | | |
| **Task**<br>6. Identify prioritization of systems to build, metrics, or associated change with separate work streams focused on implementing new Electronic Health Record Systems vs. RHIO connectivity | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| based on the DSRIP project needs and associated providers' needs | | | | | | | | | | |
| **Task** 7. Develop a roll-out plan for systems to achieve clinical data sharing and associated metrics, including a training plan to support the successful implementation of new platforms and processes | | | | | | | | | | |
| **Task** 8. Establish a process for monitoring project milestones and performance. | | | | | | | | | | |
| **Task** 9. Where electronic functionality is not yet ready, implement alternate in the interim and track conversion to electronic systems. | | | | | | | | | | |
| **Task** 10. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS | | | | | | | | | | |
| **Task** 11. Develop a process for determining how success will be measured that incorporates feedback from practitioners and other key users of IT, including financial and patient engagement impact and risks. | | | | | | | | | | |

### Prescribed Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|

No Records Found

### Prescribed Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|
| Establish ED care triage program for at-risk populations | |
| Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling.<br>a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3.<br>b. Develop process and procedures to establish connectivity | Tasks 2, 3, 8, 9, and 10 originally dated 12/31/2015 have been moved to 6/30/2016 to reflect the ongoing nature of the work. |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Prescribed Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|
| between the emergency department and community primary care providers.<br>c. Ensure real time notification to a Health Home care manager as applicable | |
| For patients presenting with minor illnesses who do not have a primary care provider:<br>a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need.<br>b. Patient navigator will assist the patient with identifying and accessing needed community support resources.<br>c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider). | Tasks 2, 3, 10, and 11 originally dated 12/31/2015 have been moved to 6/30/2016 to reflect the ongoing nature of the work. |
| Established protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.) | |
| Use EHRs and other technical platforms to track all patients engaged in the project. | |

### Milestone Review Status

| Milestone # | Review Status | IA Formal Comments |
|---|---|---|
| **Milestone #1** | Pass & Ongoing | |
| **Milestone #2** | Pass & Ongoing | |
| **Milestone #3** | Pass & Ongoing | |
| **Milestone #4** | Pass & Ongoing | |
| **Milestone #5** | Pass & Ongoing | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 2.b.iii.4 - PPS Defined Milestones

**Instructions :**

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for PPS-defined milestones.

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|

No Records Found

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC  (PPS ID:3)

**IPQR Module 2.b.iii.5 - IA Monitoring**

**Instructions :**

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Project 2.b.iv – Care transitions intervention model to reduce 30 day readmissions for chronic health conditions

#### IPQR Module 2.b.iv.1 - Major Risks to Implementation and Mitigation Strategies

**Instructions :**

Please describe what the major risks are for this project, as well as the actions you plan to take to mitigate them.

A risk to the success of this project is that care transition activities aren't currently reimbursed by Medicare/Medicaid, although some MCOs provide some level of reimbursement for care transitions plans, which vary between plans & providers. Physician practices that aren't PCMH certified are reluctant to participate. The AFBHC mitigation strategy involves using regular meetings with Medicaid MCOs to advocate for reimbursement of interventions key to the project success. The PPS is developing process improvement initiatives for providers to obtain PCMH certification, as well as agreements to incentivize providers to participate in projects & achieve desired outcomes.

There are multiple IT Risks, such as data interoperability dependent upon working with multiple vendors that may not support existing standards- the risk mitigation strategy is to engage vendors early & determine supplemental solutions where available. The RHIO, which is expected to be the interoperable clinical platform, has expressed limitations on data sharing per NY state policies, working with EHR vendors to achieve data sharing & balancing the needs of the DSRIP program with their existing commitments. The PPS will work closely with the RHIO. As Population Health IT (PHIT) systems and tools are required, any delay to PHIT implementation delays the projects & risks not meeting speed & scale requirements. As PHIT roll-out depends on sufficient capital funding from NY state, delay in the capital release will delay the rollout. The PPS will accelerate implementation of PHIT interoperability & tools, use alternate methods where EHRs & PHIT tool functionality aren't yet ready & work with NY to ensure capital is provided in sufficient time.

Inconsistent approach to transitions of care across the PPS & providers' lack of resources, knowledge & time risks success. The PPS is developing a standardized approach to engage patients & families in these services.

Another risk is lack of knowledge of the full extent of causes of readmission in the PPS. Hospitals currently rely on internal methods to monitor 30-day readmissions. Access to Medicaid claims data now provides the ability to track the movement of attributed members across sites of care internal & external to the PPS. Preliminary data reveals that hospital-based tracking methods tend to underestimate member readmissions as they only measure readmissions to the site of discharge. This measurement dynamic is a risk to the PPS as it creates disconnect between the PPS' understanding of their target performance compared with NY's measurement of their performance to target- this unfavorable gap can negatively impact incentive payments & the PPS budget. To mitigate this, the PPS is using salient data to further understand patient movement, coordinating readmission analyses across hospitals & tracking readmissions according to source (LTC, SNF, home health & home) to identify facilities, agencies & patients at higher risk of readmission than others. This data will provide a comprehensive readmission rate of the attributed population, identify care gaps & target improvements at the system root cause. The PPS will also collaborate with other PPSs in the area to ensure that strategies are in place to reduce gaps/redundancies so reduction in 30 day readmissions is attainable.

Like Project 2.b.iii, a risk to the PPS is that the successful implementation of this project will have negative impacts on the hospitals' bottom line. In the fee for service reimbursement environment, hospital admissions are associated with revenue. As avoidable admissions decline, hospital

| |
|---|
| revenues will also decline. To mitigate this risk, the PPS will monitor hospital admissions/readmissions, revenues/revenue sources, document the amount, timing & duration of the impact & allocate monies in the budget & funds flow to offset revenue losses. |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 2.b.iv.2 - Patient Engagement Speed

**Instructions :**

Enter the number of patients actively engaged through the current quarter. The number entered into the "Patient Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for DY1 Q3 should include patients previously reported in DY1 Q2 plus new patients engaged in DY1 Q3. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

| Benchmarks | |
|---|---|
| **100% Actively Engaged By** | **Expected Patient Engagement** |
| DY3,Q4 | 26,978 |

| Patients Engaged to Date in Current DY | DY1,Q3 Patient Update | % of Semi-Annual Commitment To-Date | Semi-Annual Variance of Projected to Actual | % of Total Actively Engaged Patients To-Date |
|---|---|---|---|---|
| 330 | 330 | 2.67% | 12,035 | 1.22% |

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (12,365)

### Current File Uploads

| User ID | File Type | File Name | File Description | Upload Date |
|---|---|---|---|---|
| cdomeier | Communication Documentation | 3_PMDL2815_1_3_20160129155818_DY1Q3_absense_of_patient_registry_explanation.docx | Explanation for absence of DY1, Q3 Patient Update | 01/29/2016 03:58 PM |

**Narrative Text :**

For PPS to provide additional context regarding progress and/or updates to IA.

### Module Review Status

| Review Status | IA Formal Comments |
|---|---|
| Fail | The PPS failed to meet at least 80% of its actively engaged commitments for DY1Q3. The documentation does not support the reported actively engaged numbers. |

### NYS Confidentiality – High

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 2.b.iv.3 - Prescribed Milestones

**Instructions :**

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for prescribed milestones. For milestones that are due and completed within the reporting period, documentation is required to provide evidence of project requirement achievement. Any explanations regarding altered or missed provider commitments should be included within the narrative box, not as text within uploaded documentation.

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| **Milestone #1** Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** Standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 1. PPS Clinical Operations team will conduct inventory of which PPS hospital providers and CBO's are currently providing care transitions services | Project | | Completed | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 |
| **Task** 2. Identify the current role that MCO's and Health Homes play in care transitions and the current protocols being used by these entities in the region. | Project | | Completed | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 |
| **Task** 3. Review each providers current approach/policy to care transitions services | Project | | Completed | 04/01/2015 | 09/30/2015 | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 |
| **Task** 4. The PPS will adopt a 30-day, Coleman-like model of care transitions services that includes: inpatient hospital visit from the care transitions coach, home visit post-acute discharge, medication and diagnosis review and education, symptom identification, create personal health record, secure post hospitalization PCP visit, and perform a series of follow up calls/visits after significant events during the high-risk readmission period. | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 5. Develop a post-acute network for the PPS community, | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| including level of engagement | | | | | | | | | |
| **Task**<br>6. Develop a standardized protocol for integrated clinical teams to manage population health strategies of Care Transitions services from inpatient to discharge | Project | | In Progress | 09/01/2015 | 12/31/2015 | 09/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task**<br>7. Utilize, develop and standardize education and training materials that are sensitive to cognitive competency, and culturally and linguistically tailored to the populations we serve (for example Easy To Read [ETR] materials) | Project | | In Progress | 09/01/2015 | 01/31/2016 | 09/01/2015 | 01/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task**<br>8. Establish a best practice model of service utilizing a Coleman-like model of care transitions with participating providers and CBO's | Project | | In Progress | 09/01/2015 | 03/31/2016 | 09/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task**<br>9. Complete an assessment of participating providers, LTC and CBO's of targeted high risk diagnosis (Core Measure, developmentally disabled, physical rehabilitation, & Behavioral Health/SUD), social barriers (Homeless, underinsured) and hot spotting | Project | | In Progress | 09/01/2015 | 09/30/2016 | 09/01/2015 | 09/30/2016 | 09/30/2016 | DY2 Q2 |
| **Task**<br>10. Collaborate with the Workforce Committee to create a PPS-wide strategy to redeploy/recruit the necessary professionals to support care transitions services and from the assessment of the vulnerable populations in # 4 to expand capacity and competence to include "intensive care transitions coaches" | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>11. Present standardized protocols to appropriate Clinical Integration subcommittees and Clinical Integration and Quality Committee for formal adoption. | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>12. Clinical Operations team will establish a process and structure to conduct a root cause analysis (RCA) on future failed discharges leading to readmissions within 30 days and develop process improvement plans based on data | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>9-24-15: Remediation Response<br>13. PPS will measure outcomes of the program and follow up | Project | | In Progress | 09/24/2015 | 03/31/2017 | 09/24/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| services as determined by the Clinical Integration & Quality Committee to ensure optimal success by utilizing a continuous process improvement model. | | | | | | | | | |
| **Milestone #2** Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed. | Project | N/A | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** Coordination of care strategies focused on care transition are in place, in concert with Medicaid Managed Care groups and Health Homes. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** PPS has protocol and process in place to identify Health-Home eligible patients and link them to services as required under ACA. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 1. While the AFBHC Transitions of Care Protocol is being drafted, the AFBHC CFO and project designee will meet with health plans to align discussion of projects and include health homes discussion in the region to identify consistency of practice, alignment of eligibility criteria for health homes program, and services covered. | Project | | In Progress | 09/01/2015 | 03/31/2016 | 09/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 2. Determine payment for services that are lacking, for example, transitions of care services, and define methods of coverage and payment. | Project | | In Progress | 09/01/2015 | 03/31/2016 | 09/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 3. Discuss with MCO's the cost/benefit of expanding eligibility criteria for health homes in achieving DSRIP goals and determine potential coverage options. | Project | | In Progress | 09/01/2015 | 03/31/2016 | 09/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 4. Establish AFBHC policy and procedure that defines how care transitions communications and processes will occur among entities and the role that the health plans, health homes, | Project | | In Progress | 09/01/2015 | 12/31/2017 | 09/01/2015 | 12/31/2017 | 12/31/2017 | DY3 Q3 |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| hospitals, and PPS will play. | | | | | | | | | |
| **Task**<br>5. Clearly identify in the policy and procedure how members will be linked to services as required under the Affordable Care Act. | Project | | In Progress | 09/01/2015 | 03/31/2018 | 09/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>6. Present policy to the Finance and Clinical Integration Subcommittee and Committee. | Project | | In Progress | 09/01/2015 | 03/31/2018 | 09/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>7. Establish process metrics to ensure agreed-upon procedures are working and achieving Domains 2 goals. | Project | | In Progress | 09/01/2015 | 03/31/2018 | 09/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Milestone #3**<br>Ensure required social services participate in the project. | Project | N/A | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>Required network social services, including medically tailored home food services, are provided in care transitions. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>1. Engage with network of trusted social service agencies, housing, CBOs, transportation, pharmacy associations and advocacy agencies (association for blind, deaf, etc.) in the PPS region to develop strategies to connect targeted populations to appropriate resources.<br>Submit strategies to project team and AFBHC leadership to review and for approval. | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task**<br>2. Conduct an assessment of the ability of PPS's local Meals on Wheels (MOW), regional food banks and food delivery companies to provide medically tailored meals to members identified through the care transitions planning process. | Project | | In Progress | 09/01/2015 | 03/31/2016 | 09/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task**<br>3. Clinical Operations team will assess the availability of a congregational health networks within the PPS to expand our bandwidth of providers to improve the health of our most vulnerable | Project | | In Progress | 01/01/2016 | 07/31/2016 | 01/01/2016 | 07/31/2016 | 09/30/2016 | DY2 Q2 |
| **Task**<br>4. Identify with trusted social service agencies identified in #2 and PPS stakeholders to add or enhance services that are absent or deficient by linking with project roadmap | Project | | In Progress | 01/01/2016 | 07/31/2016 | 01/01/2016 | 07/31/2016 | 09/30/2016 | DY2 Q2 |
| **Milestone #4**<br>Transition of care protocols will include early notification of | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services. | | | | | | | | | |
| **Task** Policies and procedures are in place for early notification of planned discharges. | Provider | Practitioner - Primary Care Provider (PCP) | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** Policies and procedures are in place for early notification of planned discharges. | Provider | Practitioner - Non-Primary Care Provider (PCP) | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** Policies and procedures are in place for early notification of planned discharges. | Provider | Hospital | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** PPS has program in place that allows care managers access to visit patients in the hospital and provide care transition services and advisement. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 1. Clinical Operations and Project Implementation teams will map transitions process starting from patient admission to the hospital through discharge and develop standardized systems approach for early notification of planned discharges | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 2. Clinical Integrated Teams (acute case mangers/discharge planners, social workers) will perform a risk assessment upon admission to trigger alerts to the care transitions coaches (See #1, Step 4) | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 3. Clinical Integrated Teams will collaborate with the care transitions coach to coordinate identified high-risk needs post-acute hospitalization | Project | | Completed | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 |
| **Task** 4. Care transitions coach will develop post-acute plan utilizing identified network providers, internal ancillary support personnel (Pharmacy, PT, OT), CBO/social service liaisons, and family members to support patient and provide safe hand-off after 30-day period. | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 5. Initiate steps identified in # 1, Step 7 utilizing teach back and/or return demonstration technique | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>6. Clinical Operations and Project Implementation team will establish a unified referral process to allow Clinically Integrated Teams to capture high risk patients through the facilities daily census report. | Project | | In Progress | 09/01/2015 | 03/31/2016 | 09/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task**<br>7. Clinical Operations and Project Implementation teams will engage respective IT departments to review and modify any patient access limitations to ensure Clinically Integrated Teams have access to necessary data and the ability alert care transitions service teams to contact patients and families to offer/provide care transitions services. | Project | | In Progress | 09/01/2015 | 03/31/2017 | 09/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>8. Clinical Operations Team will coordinate care transitions services with other PPS projects (2.b.iii and 2.b.viii) to fully capture the high risk patient population. | Project | | In Progress | 01/01/2016 | 03/31/2017 | 01/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #5**<br>Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>Policies and procedures are in place for including care transition plans in patient medical record and ensuring medical record is updated in interoperable EHR or updated in primary care provider record. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>1. The PPS will complete an assessment of current hospital IT policies and protocols around existing automated systems to alert post-acute providers and PCPs of transitional plans | Project | | In Progress | 10/01/2015 | 12/31/2015 | 10/01/2015 | 09/30/2016 | 09/30/2016 | DY2 Q2 |
| **Task**<br>2. Establish alternative methods of communication (secure email, fax, phone calls, physician portal) until EHR platform is operational for all transitional hand offs and PCP notification. | Project | | In Progress | 10/01/2015 | 03/31/2016 | 10/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task**<br>3. The Clinical Operations & Project Implementation team will survey participating providers to extract additional ideas surrounding timely notification of post-acute discharge dispositions | Project | | In Progress | 10/01/2015 | 12/31/2015 | 10/01/2015 | 09/30/2016 | 09/30/2016 | DY2 Q2 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>4. Clinical Operations team will adopt a standardize process/tool to exchange information at each warm hand-off (ie: Interact Like Tool) that includes significant information such as MOLST, patient care plan, medications, additional support services | Project | | In Progress | 01/01/2016 | 07/31/2016 | 01/01/2016 | 07/31/2016 | 09/30/2016 | DY2 Q2 |
| **Milestone #6**<br>Ensure that a 30-day transition of care period is established. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>1. Eligible patients enrolled in a high risk readmission process for 30-days transitions period will be assigned a care transitions coach | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task**<br>2. The care transitions coach will establish a rapport with the patient and family by initiating contact about the Coleman-like Care Transitions Program through an initial hospital visit | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task**<br>3. The care transitions coach will follow patient from hospitalization to discharge and set up a home visit within 3 business days of discharge. | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task**<br>4. The care transitions coach will perform the following interventions during the home visit with the patient/family: medication reconciliation of discharge meds, develop personal health record and create questions to be discussed at post-acute PCP visit, provide, utilizing the teach –back method, disease and medication education, provide GREEN-YELLOW-RED symptom/self-management guide sheets, establish 3 additional follow up calls/visits that surround significant health care events to provide support and establish any additional community support needs for the patient to avoid unnecessary ED visit or hospital readmission. | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task**<br>5. Track , measure and evaluate care transition programs effectiveness through data, feedback and outcomes, report through Clinical Integration and Quality committee | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| **Milestone #7** Use EHRs and other technical platforms to track all patients engaged in the project. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 1. Determine requirements for identification of targeted patients and tracking actively engaged patients per state-provided specifications for the DSRIP program. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 2. Review strategies and tools needed to promote DSRIP specific Patient Engagement for Care Transitions project | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 3. Working with the project committee, document current and future state work flow of Care Transitions project in addition to capturing manual solutions in place at this time. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 4. Assess current EHR and other technical platforms in the PPS against established requirements for patient identification and tracking, system notification and treatment plan creation | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 5. Create a gap analysis based on the work flow analysis to determine incremental IT needs and associated budget, including short-term manual solutions | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 6. Identify prioritization of systems to build or associated change with separate work streams focused on implementation new EHR systems vs RHIO connectivity based on the DSRIP project needs and associated provider's needs. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 7. Develop a roll-out plan for systems to achieve clinical data sharing, including a training plan to support the successful implementation of new platforms and processes | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 8. Establish a process for monitoring project milestones and performance | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 9. Where electronic functionality is not yet ready, implement | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| alternative in the interim and track conversion to electronic systems | | | | | | | | | |
| **Task** 10. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 11. Develop a process for determining how success will be measured that incorporates feedback from providers and other key users of IT, including financial and patient engagement impact and risks. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Milestone #1** Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency. | | | | | | | | | | |
| **Task** Standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place. | | | | | | | | | | |
| **Task** 1. PPS Clinical Operations team will conduct inventory of which PPS hospital providers and CBO's are currently providing care transitions services | | | | | | | | | | |
| **Task** 2. Identify the current role that MCO's and Health Homes play in care transitions and the current protocols being used by these entities in the region. | | | | | | | | | | |
| **Task** 3. Review each providers current approach/policy to care transitions services | | | | | | | | | | |
| **Task** 4. The PPS will adopt a 30-day, Coleman-like model of care transitions services that includes: inpatient hospital visit from the care transitions coach, home visit post-acute discharge, medication and diagnosis review and education, symptom identification, create personal health record, secure post hospitalization PCP visit, and perform a series of follow up calls/visits after significant events during the high-risk readmission period. | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>5. Develop a post-acute network for the PPS community, including level of engagement | | | | | | | | | | |
| **Task**<br>6. Develop a standardized protocol for integrated clinical teams to manage population health strategies of Care Transitions services from inpatient to discharge | | | | | | | | | | |
| **Task**<br>7. Utilize, develop and standardize education and training materials that are sensitive to cognitive competency, and culturally and linguistically tailored to the populations we serve (for example Easy To Read [ETR] materials) | | | | | | | | | | |
| **Task**<br>8. Establish a best practice model of service utilizing a Coleman-like model of care transitions with participating providers and CBO's | | | | | | | | | | |
| **Task**<br>9. Complete an assessment of participating providers, LTC and CBO's of targeted high risk diagnosis (Core Measure, developmentally disabled, physical rehabilitation, & Behavioral Health/SUD), social barriers (Homeless, underinsured) and hot spotting | | | | | | | | | | |
| **Task**<br>10. Collaborate with the Workforce Committee to create a PPS-wide strategy to redeploy/recruit the necessary professionals to support care transitions services and from the assessment of the vulnerable populations in # 4 to expand capacity and competence to include "intensive care transitions coaches" | | | | | | | | | | |
| **Task**<br>11. Present standardized protocols to appropriate Clinical Integration subcommittees and Clinical Integration and Quality Committee for formal adoption. | | | | | | | | | | |
| **Task**<br>12. Clinical Operations team will establish a process and structure to conduct a root cause analysis (RCA) on future failed discharges leading to readmissions within 30 days and develop process improvement plans based on data | | | | | | | | | | |
| **Task**<br>9-24-15: Remediation Response<br>13. PPS will measure outcomes of the program and follow up services as determined by the Clinical Integration & Quality Committee to ensure optimal success by utilizing a continuous process improvement model. | | | | | | | | | | |
| **Milestone #2**<br>Engage with the Medicaid Managed Care Organizations and | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed. | | | | | | | | | | |
| **Task** A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes. | | | | | | | | | | |
| **Task** Coordination of care strategies focused on care transition are in place, in concert with Medicaid Managed Care groups and Health Homes. | | | | | | | | | | |
| **Task** PPS has protocol and process in place to identify Health-Home eligible patients and link them to services as required under ACA. | | | | | | | | | | |
| **Task** 1. While the AFBHC Transitions of Care Protocol is being drafted, the AFBHC CFO and project designee will meet with health plans to align discussion of projects and include health homes discussion in the region to identify consistency of practice, alignment of eligibility criteria for health homes program, and services covered. | | | | | | | | | | |
| **Task** 2. Determine payment for services that are lacking, for example, transitions of care services, and define methods of coverage and payment. | | | | | | | | | | |
| **Task** 3. Discuss with MCO's the cost/benefit of expanding eligibility criteria for health homes in achieving DSRIP goals and determine potential coverage options. | | | | | | | | | | |
| **Task** 4. Establish AFBHC policy and procedure that defines how care transitions communications and processes will occur among entities and the role that the health plans, health homes, hospitals, and PPS will play. | | | | | | | | | | |
| **Task** 5. Clearly identify in the policy and procedure how members will be linked to services as required under the Affordable Care Act. | | | | | | | | | | |
| **Task** 6. Present policy to the Finance and Clinical Integration Subcommittee and Committee. | | | | | | | | | | |
| **Task** 7. Establish process metrics to ensure agreed-upon procedures are working and achieving Domains 2 goals. | | | | | | | | | | |
| **Milestone #3** Ensure required social services participate in the project. | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>Required network social services, including medically tailored home food services, are provided in care transitions. | | | | | | | | | | |
| **Task**<br>1. Engage with network of trusted social service agencies, housing, CBOs, transportation, pharmacy associations and advocacy agencies (association for blind, deaf, etc.) in the PPS region to develop strategies to connect targeted populations to appropriate resources.<br>Submit strategies to project team and AFBHC leadership to review and for approval. | | | | | | | | | | |
| **Task**<br>2. Conduct an assessment of the ability of PPS's local Meals on Wheels (MOW), regional food banks and food delivery companies to provide medically tailored meals to members identified through the care transitions planning process. | | | | | | | | | | |
| **Task**<br>3. Clinical Operations team will assess the availability of a congregational health networks within the PPS to expand our bandwidth of providers to improve the health of our most vulnerable | | | | | | | | | | |
| **Task**<br>4. Identify with trusted social service agencies identified in #2 and PPS stakeholders to add or enhance services that are absent or deficient by linking with project roadmap | | | | | | | | | | |
| **Milestone #4**<br>Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services. | | | | | | | | | | |
| **Task**<br>Policies and procedures are in place for early notification of planned discharges. | 0 | 0 | 0 | 0 | 84 | 197 | 337 | 506 | 506 | 506 |
| **Task**<br>Policies and procedures are in place for early notification of planned discharges. | 0 | 0 | 0 | 0 | 64 | 148 | 254 | 381 | 381 | 381 |
| **Task**<br>Policies and procedures are in place for early notification of planned discharges. | 0 | 0 | 0 | 0 | 2 | 5 | 9 | 13 | 13 | 13 |
| **Task**<br>PPS has program in place that allows care managers access to visit patients in the hospital and provide care transition services and advisement. | | | | | | | | | | |
| **Task**<br>1. Clinical Operations and Project Implementation teams will | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| map transitions process starting from patient admission to the hospital through discharge and develop standardized systems approach for early notification of planned discharges | | | | | | | | | | |
| **Task**<br>2. Clinical Integrated Teams (acute case mangers/discharge planners, social workers) will perform a risk assessment upon admission to trigger alerts to the care transitions coaches (See #1, Step 4) | | | | | | | | | | |
| **Task**<br>3. Clinical Integrated Teams will collaborate with the care transitions coach to coordinate identified high-risk needs post-acute hospitalization | | | | | | | | | | |
| **Task**<br>4. Care transitions coach will develop post-acute plan utilizing identified network providers, internal ancillary support personnel (Pharmacy, PT, OT), CBO/social service liaisons, and family members to support patient and provide safe hand-off after 30-day period. | | | | | | | | | | |
| **Task**<br>5. Initiate steps identified in # 1, Step 7 utilizing teach back and/or return demonstration technique | | | | | | | | | | |
| **Task**<br>6. Clinical Operations and Project Implementation team will establish a unified referral process to allow Clinically Integrated Teams to capture high risk patients through the facilities daily census report. | | | | | | | | | | |
| **Task**<br>7. Clinical Operations and Project Implementation teams will engage respective IT departments to review and modify any patient access limitations to ensure Clinically Integrated Teams have access to necessary data and the ability alert care transitions service teams to contact patients and families to offer/provide care transitions services. | | | | | | | | | | |
| **Task**<br>8. Clinical Operations Team will coordinate care transitions services with other PPS projects (2.b.iii and 2.b.viii) to fully capture the high risk patient population. | | | | | | | | | | |
| **Milestone #5**<br>Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider. | | | | | | | | | | |
| **Task**<br>Policies and procedures are in place for including care transition plans in patient medical record and ensuring medical record is updated in interoperable EHR or updated in primary care | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| provider record. | | | | | | | | | | |
| **Task**<br>1. The PPS will complete an assessment of current hospital IT policies and protocols around existing automated systems to alert post-acute providers and PCPs of transitional plans | | | | | | | | | | |
| **Task**<br>2. Establish alternative methods of communication (secure email, fax, phone calls, physician portal) until EHR platform is operational for all transitional hand offs and PCP notification. | | | | | | | | | | |
| **Task**<br>3. The Clinical Operations & Project Implementation team will survey participating providers to extract additional ideas surrounding timely notification of post-acute discharge dispositions | | | | | | | | | | |
| **Task**<br>4. Clinical Operations team will adopt a standardize process/tool to exchange information at each warm hand-off (ie: Interact Like Tool) that includes significant information such as MOLST, patient care plan, medications, additional support services | | | | | | | | | | |
| **Milestone #6**<br>Ensure that a 30-day transition of care period is established. | | | | | | | | | | |
| **Task**<br>Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized. | | | | | | | | | | |
| **Task**<br>1. Eligible patients enrolled in a high risk readmission process for 30-days transitions period will be assigned a care transitions coach | | | | | | | | | | |
| **Task**<br>2. The care transitions coach will establish a rapport with the patient and family by initiating contact about the Coleman-like Care Transitions Program through an initial hospital visit | | | | | | | | | | |
| **Task**<br>3. The care transitions coach will follow patient from hospitalization to discharge and set up a home visit within 3 business days of discharge. | | | | | | | | | | |
| **Task**<br>4. The care transitions coach will perform the following interventions during the home visit with the patient/family: medication reconciliation of discharge meds, develop personal health record and create questions to be discussed at post-acute PCP visit, provide, utilizing the teach –back method, disease and medication education, provide GREEN-YELLOW-RED symptom/self-management guide sheets, establish 3 additional | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| follow up calls/visits that surround significant health care events to provide support and establish any additional community support needs for the patient to avoid unnecessary ED visit or hospital readmission. | | | | | | | | | | |
| **Task**<br>5. Track , measure and evaluate care transition programs effectiveness through data, feedback and outcomes, report through Clinical Integration and Quality committee | | | | | | | | | | |
| **Milestone #7**<br>Use EHRs and other technical platforms to track all patients engaged in the project. | | | | | | | | | | |
| **Task**<br>PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. | | | | | | | | | | |
| **Task**<br>1. Determine requirements for identification of targeted patients and tracking actively engaged patients per state-provided specifications for the DSRIP program. | | | | | | | | | | |
| **Task**<br>2. Review strategies and tools needed to promote DSRIP specific Patient Engagement for Care Transitions project | | | | | | | | | | |
| **Task**<br>3. Working with the project committee, document current and future state work flow of Care Transitions project in addition to capturing manual solutions in place at this time. | | | | | | | | | | |
| **Task**<br>4. Assess current EHR and other technical platforms in the PPS against established requirements for patient identification and tracking, system notification and treatment plan creation | | | | | | | | | | |
| **Task**<br>5. Create a gap analysis based on the work flow analysis to determine incremental IT needs and associated budget, including short-term manual solutions | | | | | | | | | | |
| **Task**<br>6. Identify prioritization of systems to build or associated change with separate work streams focused on implementation new EHR systems vs RHIO connectivity based on the DSRIP project needs and associated provider's needs. | | | | | | | | | | |
| **Task**<br>7. Develop a roll-out plan for systems to achieve clinical data sharing, including a training plan to support the successful implementation of new platforms and processes | | | | | | | | | | |
| **Task**<br>8. Establish a process for monitoring project milestones and performance | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>9. Where electronic functionality is not yet ready, implement alternative in the interim and track conversion to electronic systems | | | | | | | | | | |
| **Task**<br>10. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS | | | | | | | | | | |
| **Task**<br>11. Develop a process for determining how success will be measured that incorporates feedback from providers and other key users of IT, including financial and patient engagement impact and risks. | | | | | | | | | | |

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Milestone #1**<br>Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency. | | | | | | | | | | |
| **Task**<br>Standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place. | | | | | | | | | | |
| **Task**<br>1. PPS Clinical Operations team will conduct inventory of which PPS hospital providers and CBO's are currently providing care transitions services | | | | | | | | | | |
| **Task**<br>2. Identify the current role that MCO's and Health Homes play in care transitions and the current protocols being used by these entities in the region. | | | | | | | | | | |
| **Task**<br>3. Review each providers current approach/policy to care transitions services | | | | | | | | | | |
| **Task**<br>4. The PPS will adopt a 30-day, Coleman-like model of care transitions services that includes: inpatient hospital visit from the care transitions coach, home visit post-acute discharge, medication and diagnosis review and education, symptom identification, create personal health record, secure post hospitalization PCP visit, and perform a series of follow up calls/visits after significant events during the high-risk readmission period. | | | | | | | | | | |
| **Task**<br>5. Develop a post-acute network for the PPS community, | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| including level of engagement | | | | | | | | | | |
| **Task**<br>6. Develop a standardized protocol for integrated clinical teams to manage population health strategies of Care Transitions services from inpatient to discharge | | | | | | | | | | |
| **Task**<br>7. Utilize, develop and standardize education and training materials that are sensitive to cognitive competency, and culturally and linguistically tailored to the populations we serve (for example Easy To Read [ETR] materials) | | | | | | | | | | |
| **Task**<br>8. Establish a best practice model of service utilizing a Coleman-like model of care transitions with participating providers and CBO's | | | | | | | | | | |
| **Task**<br>9. Complete an assessment of participating providers, LTC and CBO's of targeted high risk diagnosis (Core Measure, developmentally disabled, physical rehabilitation, & Behavioral Health/SUD), social barriers (Homeless, underinsured) and hot spotting | | | | | | | | | | |
| **Task**<br>10. Collaborate with the Workforce Committee to create a PPS-wide strategy to redeploy/recruit the necessary professionals to support care transitions services and from the assessment of the vulnerable populations in # 4 to expand capacity and competence to include "intensive care transitions coaches" | | | | | | | | | | |
| **Task**<br>11. Present standardized protocols to appropriate Clinical Integration subcommittees and Clinical Integration and Quality Committee for formal adoption. | | | | | | | | | | |
| **Task**<br>12. Clinical Operations team will establish a process and structure to conduct a root cause analysis (RCA) on future failed discharges leading to readmissions within 30 days and develop process improvement plans based on data | | | | | | | | | | |
| **Task**<br>9-24-15: Remediation Response<br>13. PPS will measure outcomes of the program and follow up services as determined by the Clinical Integration & Quality Committee to ensure optimal success by utilizing a continuous process improvement model. | | | | | | | | | | |
| **Milestone #2**<br>Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| ensure appropriate post-discharge protocols are followed. | | | | | | | | | | |
| **Task** A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes. | | | | | | | | | | |
| **Task** Coordination of care strategies focused on care transition are in place, in concert with Medicaid Managed Care groups and Health Homes. | | | | | | | | | | |
| **Task** PPS has protocol and process in place to identify Health-Home eligible patients and link them to services as required under ACA. | | | | | | | | | | |
| **Task** 1. While the AFBHC Transitions of Care Protocol is being drafted, the AFBHC CFO and project designee will meet with health plans to align discussion of projects and include health homes discussion in the region to identify consistency of practice, alignment of eligibility criteria for health homes program, and services covered. | | | | | | | | | | |
| **Task** 2. Determine payment for services that are lacking, for example, transitions of care services, and define methods of coverage and payment. | | | | | | | | | | |
| **Task** 3. Discuss with MCO's the cost/benefit of expanding eligibility criteria for health homes in achieving DSRIP goals and determine potential coverage options. | | | | | | | | | | |
| **Task** 4. Establish AFBHC policy and procedure that defines how care transitions communications and processes will occur among entities and the role that the health plans, health homes, hospitals, and PPS will play. | | | | | | | | | | |
| **Task** 5. Clearly identify in the policy and procedure how members will be linked to services as required under the Affordable Care Act. | | | | | | | | | | |
| **Task** 6. Present policy to the Finance and Clinical Integration Subcommittee and Committee. | | | | | | | | | | |
| **Task** 7. Establish process metrics to ensure agreed-upon procedures are working and achieving Domains 2 goals. | | | | | | | | | | |
| **Milestone #3** Ensure required social services participate in the project. | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>Required network social services, including medically tailored home food services, are provided in care transitions. | | | | | | | | | | |
| **Task**<br>1. Engage with network of trusted social service agencies, housing, CBOs, transportation, pharmacy associations and advocacy agencies (association for blind, deaf, etc.) in the PPS region to develop strategies to connect targeted populations to appropriate resources.<br>Submit strategies to project team and AFBHC leadership to review and for approval. | | | | | | | | | | |
| **Task**<br>2. Conduct an assessment of the ability of PPS's local Meals on Wheels (MOW), regional food banks and food delivery companies to provide medically tailored meals to members identified through the care transitions planning process. | | | | | | | | | | |
| **Task**<br>3. Clinical Operations team will assess the availability of a congregational health networks within the PPS to expand our bandwidth of providers to improve the health of our most vulnerable | | | | | | | | | | |
| **Task**<br>4. Identify with trusted social service agencies identified in #2 and PPS stakeholders to add or enhance services that are absent or deficient by linking with project roadmap | | | | | | | | | | |
| **Milestone #4**<br>Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services. | | | | | | | | | | |
| **Task**<br>Policies and procedures are in place for early notification of planned discharges. | 506 | 506 | 506 | 506 | 506 | 506 | 506 | 506 | 506 | 506 |
| **Task**<br>Policies and procedures are in place for early notification of planned discharges. | 381 | 381 | 381 | 381 | 381 | 381 | 381 | 381 | 381 | 381 |
| **Task**<br>Policies and procedures are in place for early notification of planned discharges. | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 |
| **Task**<br>PPS has program in place that allows care managers access to visit patients in the hospital and provide care transition services and advisement. | | | | | | | | | | |
| **Task**<br>1. Clinical Operations and Project Implementation teams will | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| map transitions process starting from patient admission to the hospital through discharge and develop standardized systems approach for early notification of planned discharges | | | | | | | | | | |
| **Task**<br>2. Clinical Integrated Teams (acute case mangers/discharge planners, social workers) will perform a risk assessment upon admission to trigger alerts to the care transitions coaches (See #1, Step 4) | | | | | | | | | | |
| **Task**<br>3. Clinical Integrated Teams will collaborate with the care transitions coach to coordinate identified high-risk needs post-acute hospitalization | | | | | | | | | | |
| **Task**<br>4. Care transitions coach will develop post-acute plan utilizing identified network providers, internal ancillary support personnel (Pharmacy, PT, OT), CBO/social service liaisons, and family members to support patient and provide safe hand-off after 30-day period. | | | | | | | | | | |
| **Task**<br>5. Initiate steps identified in # 1, Step 7 utilizing teach back and/or return demonstration technique | | | | | | | | | | |
| **Task**<br>6. Clinical Operations and Project Implementation team will establish a unified referral process to allow Clinically Integrated Teams to capture high risk patients through the facilities daily census report. | | | | | | | | | | |
| **Task**<br>7. Clinical Operations and Project Implementation teams will engage respective IT departments to review and modify any patient access limitations to ensure Clinically Integrated Teams have access to necessary data and the ability alert care transitions service teams to contact patients and families to offer/provide care transitions services. | | | | | | | | | | |
| **Task**<br>8. Clinical Operations Team will coordinate care transitions services with other PPS projects (2.b.iii and 2.b.viii) to fully capture the high risk patient population. | | | | | | | | | | |
| **Milestone #5**<br>Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider. | | | | | | | | | | |
| **Task**<br>Policies and procedures are in place for including care transition plans in patient medical record and ensuring medical record is updated in interoperable EHR or updated in primary care | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| provider record. | | | | | | | | | | |
| **Task**<br>1. The PPS will complete an assessment of current hospital IT policies and protocols around existing automated systems to alert post-acute providers and PCPs of transitional plans | | | | | | | | | | |
| **Task**<br>2. Establish alternative methods of communication (secure email, fax, phone calls, physician portal) until EHR platform is operational for all transitional hand offs and PCP notification. | | | | | | | | | | |
| **Task**<br>3. The Clinical Operations & Project Implementation team will survey participating providers to extract additional ideas surrounding timely notification of post-acute discharge dispositions | | | | | | | | | | |
| **Task**<br>4. Clinical Operations team will adopt a standardize process/tool to exchange information at each warm hand-off (ie: Interact Like Tool) that includes significant information such as MOLST, patient care plan, medications, additional support services | | | | | | | | | | |
| **Milestone #6**<br>Ensure that a 30-day transition of care period is established. | | | | | | | | | | |
| **Task**<br>Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized. | | | | | | | | | | |
| **Task**<br>1. Eligible patients enrolled in a high risk readmission process for 30-days transitions period will be assigned a care transitions coach | | | | | | | | | | |
| **Task**<br>2. The care transitions coach will establish a rapport with the patient and family by initiating contact about the Coleman-like Care Transitions Program through an initial hospital visit | | | | | | | | | | |
| **Task**<br>3. The care transitions coach will follow patient from hospitalization to discharge and set up a home visit within 3 business days of discharge. | | | | | | | | | | |
| **Task**<br>4. The care transitions coach will perform the following interventions during the home visit with the patient/family: medication reconciliation of discharge meds, develop personal health record and create questions to be discussed at post-acute PCP visit, provide, utilizing the teach –back method, disease and medication education, provide GREEN-YELLOW-RED symptom/self-management guide sheets, establish 3 additional | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| follow up calls/visits that surround significant health care events to provide support and establish any additional community support needs for the patient to avoid unnecessary ED visit or hospital readmission. | | | | | | | | | | |
| **Task**<br>5. Track , measure and evaluate care transition programs effectiveness through data, feedback and outcomes, report through Clinical Integration and Quality committee | | | | | | | | | | |
| **Milestone #7**<br>Use EHRs and other technical platforms to track all patients engaged in the project. | | | | | | | | | | |
| **Task**<br>PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. | | | | | | | | | | |
| **Task**<br>1. Determine requirements for identification of targeted patients and tracking actively engaged patients per state-provided specifications for the DSRIP program. | | | | | | | | | | |
| **Task**<br>2. Review strategies and tools needed to promote DSRIP specific Patient Engagement for Care Transitions project | | | | | | | | | | |
| **Task**<br>3. Working with the project committee, document current and future state work flow of Care Transitions project in addition to capturing manual solutions in place at this time. | | | | | | | | | | |
| **Task**<br>4. Assess current EHR and other technical platforms in the PPS against established requirements for patient identification and tracking, system notification and treatment plan creation | | | | | | | | | | |
| **Task**<br>5. Create a gap analysis based on the work flow analysis to determine incremental IT needs and associated budget, including short-term manual solutions | | | | | | | | | | |
| **Task**<br>6. Identify prioritization of systems to build or associated change with separate work streams focused on implementation new EHR systems vs RHIO connectivity based on the DSRIP project needs and associated provider's needs. | | | | | | | | | | |
| **Task**<br>7. Develop a roll-out plan for systems to achieve clinical data sharing, including a training plan to support the successful implementation of new platforms and processes | | | | | | | | | | |
| **Task**<br>8. Establish a process for monitoring project milestones and performance | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task** 9. Where electronic functionality is not yet ready, implement alternative in the interim and track conversion to electronic systems | | | | | | | | | | |
| **Task** 10. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS | | | | | | | | | | |
| **Task** 11. Develop a process for determining how success will be measured that incorporates feedback from providers and other key users of IT, including financial and patient engagement impact and risks. | | | | | | | | | | |

### Prescribed Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|

No Records Found

### Prescribed Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|
| Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency. | Task 6 originally dated 12/31/2015 has been moved to 3/31/2016 to reflect the ongoing nature of the work. |
| Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed. | |
| Ensure required social services participate in the project. | |
| Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services. | Tasks 1, 2, 4, and 5 originally dated 12/31/2015 have been moved to 3/31/2016 to reflect the ongoing nature of the work. |
| Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider. | Tasks 1 and 3 originally dated 12/31/2015 have been moved to 9/30/2016 to reflect the ongoing nature of the work. |
| Ensure that a 30-day transition of care period is established. | |
| Use EHRs and other technical platforms to track all patients engaged in the project. | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Milestone Review Status

| Milestone # | Review Status | IA Formal Comments |
|---|---|---|
| **Milestone #1** | Pass & Ongoing | |
| **Milestone #2** | Pass & Ongoing | |
| **Milestone #3** | Pass & Ongoing | |
| **Milestone #4** | Pass & Ongoing | |
| **Milestone #5** | Pass & Ongoing | |
| **Milestone #6** | Pass & Ongoing | |
| **Milestone #7** | Pass & Ongoing | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 2.b.iv.4 - PPS Defined Milestones

**Instructions :**

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for PPS-defined milestones.

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|

No Records Found

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC  (PPS ID:3)

**IPQR Module 2.b.iv.5 - IA Monitoring**

**Instructions :**

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Project 2.b.viii – Hospital-Home Care Collaboration Solutions

#### IPQR Module 2.b.viii.1 - Major Risks to Implementation and Mitigation Strategies

**Instructions :**

Please describe what the major risks are for this project, as well as the actions you plan to take to mitigate them.

This project's success may risk hospitals' bottom line. As avoidable admissions decline, hospital revenues may decline. To mitigate the risk, the PPS will monitor hospital admissions/readmissions, revenues/revenue sources, document the impact & allocate monies in the budget & funds flow to offset losses.
As the project effects patient volume, hospitals may experience overstaffing. The PPS will monitor volume/productivity closely & coordinate with the Workforce Committee to retrain/redeploy workers within the PPS if necessary.
There are many IT Risks, such as data interoperability using multiple vendors that may not support existing standards- the risk mitigation strategy is to engage vendors early & determine supplemental solutions if available. The RHIO, which is expected to be the interoperable clinical platform, has expressed limitations on data sharing per NY state policies, working with EHR vendors to achieve data sharing & balancing the needs of DSRIP with existing commitments. As Population Health IT (PHIT) systems & tools are required, any delay to PHIT implementation delays the projects & risks not meeting speed & scale requirements. PHIT rollout depends on sufficient capital funding from NY state & delay in capital release will delay the rollout. The PPS will work with the RHIO, accelerate implementation of PHIT interoperability, use alternate methods where EHRs & PHIT tool functionality aren't ready & work with NY to ensure capital is given in sufficient time.
Another risk success is limited availability to the full extent of readmissions in the PPS. Hospitals have relied on internal methods to monitor readmissions. Access to Medicaid claims data now allows tracking attributed member movement across care sites in & out of the PPS. Preliminary data reveals that hospital tracking methods underestimate readmissions as they measure readmissions to the site of discharge. This dynamic is a risk as it creates disconnect between the PPS' understanding of their target performance compared with NY's measurement- this gap can negatively impact incentive payments & the PPS budget. For mitigation, the PPS is using data to understand patient movement, coordinating & tracking readmissions according to source (LTC, SNF, home health & home) to identify facilities, agencies & patients at higher risk of readmission. This will provide a comprehensive readmission rate of the attributed population, identify care gaps & target improvements at the system root cause
The home-health process will include protocols to identify worsening patient status early, evaluate condition & direct patients to appropriate care.
Collaboration with other project strategies will help achieve speed & scale. The actively engaged patient in this project is the number of participating patients who avoided homecare to hospital transfer due to INTERACT-like principles. As submitted in the original application, the PPS actively engaged target is based on estimated members receiving homecare as of 12/2014. We assume that 50% of patients managed in the prior year continue to be engaged in active management of their chronic conditions. DSRIP success in other areas (25% Asthma and 33% Care Transitions) will drive growth of members with homecare above historical levels.
Due to varying documentation methods among the participating home health agencies, care processes are at risk from miscommunication & missing info. To mitigate the risk, this project will work with the IT committee to use consistent electronic tools across agencies. The PPS will assess the current use of the INTERACT program & implement standardized INTERACT tools. Project leads will assess current state readiness & willingness to participate & coordinate strategies with the PPS if roadblocks to change are found. Project goals will be evaluated quarterly to ensure milestones are on track for success.

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 2.b.viii.2 - Patient Engagement Speed

**Instructions :**

Enter the number of patients actively engaged through the current quarter. The number entered into the "Patient Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for DY1 Q3 should include patients previously reported in DY1 Q2 plus new patients engaged in DY1 Q3. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

| Benchmarks | |
|---|---|
| **100% Actively Engaged By** | **Expected Patient Engagement** |
| DY4,Q4 | 13,057 |

| Patients Engaged to Date in Current DY | DY1,Q3 Patient Update | % of Semi-Annual Commitment To-Date | Semi-Annual Variance of Projected to Actual | % of Total Actively Engaged Patients To-Date |
|---|---|---|---|---|
| 0 | 0 | 0.00% | 3,751 | 0.00% |

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (3,751)

### Current File Uploads

| User ID | File Type | File Name | File Description | Upload Date |
|---|---|---|---|---|
| cdomeier | Communication Documentation | 3_PMDL3315_1_3_20160129155938_DY1Q3_absense_of_patient_registry_explanation.docx | Explanation for absence of DY1, Q3 Patient Update | 01/29/2016 03:59 PM |

**Narrative Text :**

For PPS to provide additional context regarding progress and/or updates to IA.

### Module Review Status

| Review Status | IA Formal Comments |
|---|---|
| Fail | The PPS failed to meet at least 80% of its actively engaged commitments for DY1Q3. The documentation does not support the reported actively engaged numbers. |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 2.b.viii.3 - Prescribed Milestones

**Instructions :**

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for prescribed milestones. For milestones that are due and completed within the reporting period, documentation is required to provide evidence of project requirement achievement. Any explanations regarding altered or missed provider commitments should be included within the narrative box, not as text within uploaded documentation.

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| **Milestone #1**<br>Assemble Rapid Response Teams (hospital/home care) to facilitate patient discharge to home and assure needed home care services are in place, including, if appropriate, hospice. | Project | N/A | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>Rapid Response Teams are facilitating hospital-home care collaboration, with procedures and protocols for:<br>- discharge planning<br>- discharge facilitation<br>- confirmation of home care services | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>1. Identify project lead at PPS level | Project | | Completed | 04/01/2015 | 11/30/2015 | 04/01/2015 | 11/30/2015 | 12/31/2015 | DY1 Q3 |
| **Task**<br>2. Form project implementation teams at each site, including case management and home care administrative and front line staff and PPS providers | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task**<br>3. St Mary's Hospital, Amsterdam; Ellis Hospital; St Peter's Hospital; Samaritan Hospital, St Mary's Hospital, Troy; and Albany Memorial Hospital partner hospitals will participate in development of early discharge identification process for home care service integration with Community Health Center, The Eddy and Visiting Nurse Service of Schenectady. (*Expedited Discharge Team [EDT] in lieu of Rapid Response Team name) | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>4. Include existing Coleman trained care transitions coaches (CTC) to assist in development of discharge teams | Project | | In Progress | 10/01/2015 | 12/31/2015 | 10/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task**<br>5. Complete a current state baseline of discharge processes, home care integration, palliative care and hospice involvement. | Project | | Completed | 10/01/2015 | 12/31/2015 | 10/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>6. Define future state for the hospital to home-care collaboration programs with INTERACT-like techniques<br>• Include collaboration during hospital visit to include home care liaison for greater acceptance of services being offered | Project | | In Progress | 10/01/2015 | 09/30/2016 | 10/01/2015 | 09/30/2016 | 09/30/2016 | DY2 Q2 |
| **Task**<br>7. Integrate behavioral health concerns into process, including screening tools and appropriate referrals | Project | | In Progress | 10/01/2015 | 09/30/2016 | 10/01/2015 | 09/30/2016 | 09/30/2016 | DY2 Q2 |
| **Task**<br>8. Present recommendations and periodic updates to the Clinical Integration and Quality committee of the PPS on project methodology | Project | | In Progress | 10/01/2015 | 09/30/2016 | 10/01/2015 | 09/30/2016 | 09/30/2016 | DY2 Q2 |
| **Task**<br>9. Implement clinical guidelines for hospital discharges to home care services. | Project | | In Progress | 10/01/2015 | 03/31/2018 | 10/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>10. Establish two way communication with hospital and home care that services have been initiated when patient discharged.<br>• Home care will also report back to the hospital regarding patients referred but not admitted to home health because the patient cancelled once they got home or they were not home/not found, etc.. | Project | | In Progress | 01/01/2016 | 03/31/2018 | 01/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Milestone #2**<br>Ensure home care staff have knowledge and skills to identify and respond to patient risks for readmission, as well as to support evidence-based medicine and chronic care management. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>Staff trained on care model, specific to:<br>- patient risks for readmission<br>- evidence-based preventive medicine<br>- chronic disease management | Provider | Home Care Facilities | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>Evidence-based guidelines for chronic-condition management implemented. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>1. Asses current tools and educational offering utilized by home care staff for identification of changes in condition, chronic disease management, etc | Project | | In Progress | 01/01/2016 | 03/31/2017 | 01/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| **Task** 2. Identify and obtain INTERACT-like tools that are needed to be used to educate home care | Project | | In Progress | 01/01/2016 | 03/31/2017 | 01/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 3. Determine resources needed for training, such as modules, train the trainer methods or direct education | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 4. Develop education plan and timeline for home care staff | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 5. Secure resources needed for training sessions, using INTERACT-like tools to supplement gaps in education needs | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 6. Train staff on chosen care model, focus on changes in patient condition, evidence based preventive medicine care coordination and chronic disease management | Project | | In Progress | 07/01/2016 | 03/31/2017 | 07/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 7. Document, track and aggregate evaluations of all training sessions using a learning management software (LMS) tool provided by the PPS. | Project | | In Progress | 07/01/2016 | 03/31/2017 | 07/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 8. Revise education methods as necessary to meet the needs of the participants | Project | | In Progress | 07/01/2016 | 03/31/2017 | 07/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #3** Develop care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** Care pathways and clinical tool(s) created to monitor chronically-ill patients. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** PPS has developed and implemented interventions aimed at avoiding eventual hospital transfer and has trained staff on use of interventions in alignment with the PPS strategic plan to monitor critically ill patients and avoid hospital readmission. | Provider | Safety Net Hospital | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 1. Using INTERACT-like tools develop care pathways for home care to monitor chronically-ill patients | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 2. Through provider agreements, include guidance on when to | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| notify primary care physician of change in condition | | | | | | | | | |
| **Task**<br>3. Focus on care pathways with INTERACT-like tools on at home care level of recognition<br>• Acute mental status change<br>• Changes in vital signs<br>• Change in behavior<br>• Observed change in fluid intake and output<br>• Fever or change in temperature<br>• Nausea, vomiting, diarrhea<br>• Symptoms of lower respiratory illness<br>• Symptoms of CHF<br>• Symptoms of UTI | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>4. Work with IT resources through the PPS to help track readmissions | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>5. Establish quality review methodology for review of care pathways, adapt to improve outcomes | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>6. Link to interventions developed with other projects, such as care transition project, integration of behavioral health & palliative care | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>7. Pilot EHR programs and software solutions to home care teams, work with IT consultants to assess feasibility of piloting programs | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>8. Present recommendations to the Clinical Integration and Quality committee of the PPS on project methodology | Project | | In Progress | 07/01/2016 | 03/31/2017 | 07/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>9. Train staff on guidelines | Project | | In Progress | 07/01/2016 | 03/31/2017 | 07/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #4**<br>Educate all staff on care pathways and INTERACT-like principles. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>Training program for all home care staff established, which | Provider | Home Care Facilities | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| encompasses care pathways and INTERACT-like principles. | | | | | | | | | |
| **Task**<br>1. Develop training programs for home care staff based on INTERACT-like tools.<br>Provide education to PCP and their staff on the use of home care services and pathways utilized to prevent hospitalization and avoiding readmission | Project | | In Progress | 01/01/2016 | 03/31/2017 | 01/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>2. Develop learning programs for home care staff, including early warning tools and communication tools | Project | | In Progress | 01/01/2016 | 03/31/2017 | 01/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>3. Include education for home care staff on needs of special populations, including intellectually and developmentally disabled members | Project | | In Progress | 01/01/2016 | 03/31/2017 | 01/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>4. Conduct initial and annual training sessions for home care staff | Project | | In Progress | 01/01/2016 | 03/31/2017 | 01/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>5. Collaborate with Workforce Committee of the PPS to develop training programs for new hires, retrained and/or re-deployed staff. | Project | | In Progress | 01/01/2016 | 03/31/2017 | 01/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>6. Maintain list of trainings, participants, evaluations and curriculum revisions through PPS based Learning Management System ( LMS) tool | Project | | In Progress | 01/01/2016 | 03/31/2017 | 01/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>7. Develop plan with cultural competency and health literacy taskforce education specific to cultural differences and end of life care | Project | | In Progress | 01/01/2016 | 03/31/2017 | 01/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>8. Evaluate, review and update training materials as needed and/or as recommended by Clinical Integration and Quality committee | Project | | In Progress | 01/01/2016 | 03/31/2017 | 01/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #5**<br>Develop Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>Advance Care Planning tools incorporated into program (as | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| evidenced by policies and procedures). | | | | | | | | | |
| **Task** 1. Identify Advance Care planning tools including communication guide, tracking tool, comfort order set, and educational materials for patient and families. Provide education to staff on advance care planning, MOLST, and palliative care. Include subject matter experts such as Hospice Teams to assist in educational sessions | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 2. Assess current state tools that are available to patients and families | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 3. Adopt Advance Care planning tools to supplement existing tools for patients and families. | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 4. Use INTERACT-like principals to address options for palliative and end of life care if appropriate. | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 5. Script discussions with patients and families regarding accessibility to forms | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 6. Explore innovative ways to identify tools, ie: magnetize, ID alerts, software apps | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 7. Coordinate with Cultural Competency and Health Literacy task force of the PPS inclusion of age appropriate, culturally sensitive care planning tools | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 8. Track, trend and benchmark defined measures related to INTERACT-like advance care planning tools. | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 9. Identify areas for improvement if necessary and report through the Clinical Integration and Quality Committee care improvement activities | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #6** Create coaching program to facilitate and support implementation. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** INTERACT-like coaching program has been established for all | Provider | Home Care Facilities | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| home care and Rapid Response Team staff. | | | | | | | | | |
| **Task** 1. Identify INTERACT-like coaching program for the home care and expedited discharge teams | Project | | In Progress | 01/01/2016 | 03/31/2017 | 01/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 2. Identify champion(s) for the program at sites to motivate and assist in coordination of the program. | Project | | In Progress | 01/01/2016 | 03/31/2017 | 01/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 3. Identify coaching tools on INTERACT-like to guide implementation Use communication tools that support engagement with hospitals and home care agencies | Project | | In Progress | 01/01/2016 | 03/31/2017 | 01/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 4. Schedule and conduct strategic meetings with hospitals and home care agencies to evaluate development, implementation and outcomes of programs | Project | | In Progress | 01/01/2016 | 03/31/2017 | 01/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 5. Integrate coaching program with overlapping projects of the PPS, including Care Transitions project (2.b.iv) and ED Care Triage project (2.b.iii). | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 6. Integrate technology platforms and solutions recommended by the PPS IT committee to support program implementation. | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 7. Implement quality improvement cycle to evaluate outcomes through metrics | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 8. Use quality improvement tools to coach home care education and care process improvements. | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #7** Educate patient and family/caretakers, to facilitate participation in planning of care. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** Patients and families educated and involved in planning of care using INTERACT-like principles. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 1. Collaborate with education vendors to purchase patient and family focused education | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 2. Assess what is currently being used by health care workers in | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| the home environment | | | | | | | | | |
| **Task** 3. Include patient and family education components with INTERACT-like solutions. Identify, develop patient/family education tools that address health literacy/cultural sensitivity & utilize technology such as videos, tablets to address principles of adult education | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 4. Patient and family education sections to include education for family members to recognize change in condition and communication avenues regarding change. | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 5. Include discussions with patient and families risks and benefits of hospitalization using INTERACT-like advance care planning tools. | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 6. Establish a patient and family-oriented teach back program for early identification of adverse effects of medication | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 7. Establish a patient and family-oriented teach back program for understanding of early comfort measures | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 8. Establish quality review methods through the Clinical Integration and Quality committee of the PPS to evaluate patient hospital readmission for those who have received the aforementioned training, and use root cause analysis to revise methodology as necessary to enhance participation. | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 9. As sites are phased in, track and evaluate programs at each site using rapid cycle team evaluation techniques | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 10. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 11. Communicate with hospitals and home care agencies level of success of program quarterly | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #8** Integrate primary care, behavioral health, pharmacy, and other services into the model in order to enhance coordination of care | Project | N/A | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| and medication management. | | | | | | | | | |
| **Task** All relevant services (physical, behavioral, pharmacological) integrated into care and medication management model. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 1. Identify INTERACT-like processes that include medication management for hospital to home care collaboration. | Project | | In Progress | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 2. Explore pharmacy support for homecare when evaluating care models | Project | | In Progress | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 3. Assess providers and entities that use INTERACT-like interventions in practices, including primary care, PCMH, hospitals, mental health providers, home health organizations, Health home, pharmacies, community based organizations, etc. | Project | | In Progress | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 4. Include members of all provider types on project teams | Project | | In Progress | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 5. Develop future state care coordination and medication management model | Project | | In Progress | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 6. Use home care tools, including advance care planning, monitored medication dispensers, medication reconciliation worksheets, early change in condition tools, SBAR communication tools that reflect all relevant services | Project | | In Progress | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 7. Work with project managers/directors, leads and champions of other projects within the PPS, and PPS leadership to establish, strengthen and enhance integration of projects to include INTERACT-like tools for home health care. | Project | | In Progress | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 8. Extend educational sessions to providers and entities on care and medication model | Project | | In Progress | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 9. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | Project | | In Progress | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 10. Track and evaluate programs at each site using rapid cycle team evaluation techniques | Project | | In Progress | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| **Task** 11. Consider pilot program on medication reconciliation with community resources and pharmacies for disposal, removal, and poly-pharmacy reconciliation | Project | | In Progress | 07/01/2016 | 03/31/2018 | 07/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Milestone #9** Utilize telehealth/telemedicine to enhance hospital-home care collaborations. | Project | N/A | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** Telehealth/telemedicine program established to provide care transition services, prevent avoidable hospital use, and increase specialty expertise of PCPs and staff. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 1. Determine requirements and needs assessment for technology assisted services (telehealth/ telemedicine) program within the PPS | Project | | In Progress | 01/01/2016 | 03/31/2018 | 01/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 2. Assess current telehealth/telemedicine use and other technical platforms in the PPS to evaluate opportunities. | Project | | In Progress | 01/01/2016 | 03/31/2018 | 01/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 3. Update existing telehealth systems for more desired state of the art technology and expand best practices to enhance the use and unitization of telehealth for high risk patients | Project | | In Progress | 01/01/2016 | 03/31/2018 | 01/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 4. Determine incremental IT needs and associated financial implications, including short-term solutions | Project | | In Progress | 01/01/2016 | 03/31/2018 | 01/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 5. Establish a process for monitoring telehealth/telemedicine milestones and performance. | Project | | In Progress | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 6. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS. | Project | | In Progress | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 7. Consider piloting a telemedicine program for a specific high risk diagnosis and care pathway as identified in our Community Needs Assessment. Utilizing existing model / data from results of RCA's for readmissions. | Project | | In Progress | 07/01/2016 | 03/31/2018 | 07/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 8. Data analysis will be shared with partners and Managed Care Organizations. | Project | | In Progress | 07/01/2016 | 03/31/2018 | 07/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| **Milestone #10** Utilize interoperable EHR to enhance communication and avoid medication errors and/or duplicative services. | Project | N/A | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** Clinical Interoperability System in place for all participating providers. Usage documented by the identified care coordinators. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 1. Determine requirements for clinical interoperability system | Project | | In Progress | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 2. Assess current EHR and other technical platforms in the PPS against these requirements | Project | | In Progress | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 3. Determine method to identify the best source for medication reconciliation | Project | | In Progress | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 4. Determine incremental IT needs and associated budget, including short-term solutions | Project | | In Progress | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 5. Establish a process for monitoring project milestones and performance. | Project | | In Progress | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 6. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS. | Project | | In Progress | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Milestone #11** Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions. | Project | N/A | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics in Attachment J. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |

# New York State Department Of Health
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## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| **Task** Service and quality outcome measures are reported to all stakeholders. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 1. Identify members of Clinical Integration and Quality committee, including project lead and teams from hospital and home care | Project | | In Progress | 10/01/2015 | 03/31/2018 | 10/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 2. Incorporate existing quality improvement process from existing home care agencies | Project | | In Progress | 10/01/2015 | 03/31/2018 | 10/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 3. Project committee benchmark, track and trend defined measures | Project | | In Progress | 01/01/2016 | 03/31/2018 | 01/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 4. Develop process for rapid cycle improvement methodologies focusing on root cause analysis (RCA) of hospital transfer Use INTERACT like tools, such as acute care transfer logs, to track and trend transfers | Project | | In Progress | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 5. Project lead/champions and other home health key stakeholders to aggregate data to summarize finding and trends from individual hospital transfers into quality improvement tool on monthly basis | Project | | In Progress | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 6. Quality improvement committee members to recommend outcome improvement efforts based on trending data and action plans related to applicable metrics | Project | | In Progress | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 7. Track and evaluate programs at each site using rapid cycle team evaluation techniques and report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | Project | | In Progress | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Milestone #12** Use EHRs and other technical platforms to track all patients engaged in the project. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| 1. Determine requirements for identification of targeted patients and tracking actively engaged patients per state-provided specifications for the DSRIP program. | | | | | | | | | |
| **Task** 2. Review strategies and tools needed to promote DSRIP specific Patient Engagement | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 3. Working with the project team document current and future state work flow in addition to capturing manual solutions in place at this time | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 4. Monitor partnering sites that are unable to meet metrics and goals and develop process improving plan with AFBHC leadership team to gain full attainment of partner contract requirements | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 5. Create a gap analysis based on the work flow analysis to determine incremental IT needs and associated budget, including short-term manual solutions | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 6. Identify prioritization of systems to build or associated change with separate work streams focused on implementing new Electronic Health Record Systems vs. RHIO connectivity based on the project needs and associated providers' needs | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 7. Develop a roll-out plan for systems to achieve clinical data sharing, including a training plan to support the successful implementation of new platforms and processes | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 8. Establish a process for monitoring project milestones and performance | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 9. Where electronic functionality is not yet ready, implement alternate in the interim and track conversion to electronic systems. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 10. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| 11. Develop a process for determining how success will be measured that incorporates feedback from providers and other key users of IT, including financial and patient engagement impact and risks. | | | | | | | | | |

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Milestone #1**<br>Assemble Rapid Response Teams (hospital/home care) to facilitate patient discharge to home and assure needed home care services are in place, including, if appropriate, hospice. | | | | | | | | | | |
| **Task**<br>Rapid Response Teams are facilitating hospital-home care collaboration, with procedures and protocols for:<br>- discharge planning<br>- discharge facilitation<br>- confirmation of home care services | | | | | | | | | | |
| **Task**<br>1. Identify project lead at PPS level | | | | | | | | | | |
| **Task**<br>2. Form project implementation teams at each site, including case management and home care administrative and front line staff and PPS providers | | | | | | | | | | |
| **Task**<br>3. St Mary's Hospital, Amsterdam; Ellis Hospital; St Peter's Hospital; Samaritan Hospital, St Mary's Hospital, Troy; and Albany Memorial Hospital partner hospitals will participate in development of early discharge identification process for home care service integration with Community Health Center, The Eddy and Visiting Nurse Service of Schenectady. (*Expedited Discharge Team [EDT] in lieu of Rapid Response Team name) | | | | | | | | | | |
| **Task**<br>4. Include existing Coleman trained care transitions coaches (CTC) to assist in development of discharge teams | | | | | | | | | | |
| **Task**<br>5. Complete a current state baseline of discharge processes, home care integration, palliative care and hospice involvement. | | | | | | | | | | |
| **Task**<br>6. Define future state for the hospital to home-care collaboration programs with INTERACT-like techniques<br>• Include collaboration during hospital visit to include home care liaison for greater acceptance of services being offered | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>7. Integrate behavioral health concerns into process, including screening tools and appropriate referrals | | | | | | | | | | |
| **Task**<br>8. Present recommendations and periodic updates to the Clinical Integration and Quality committee of the PPS on project methodology | | | | | | | | | | |
| **Task**<br>9. Implement clinical guidelines for hospital discharges to home care services. | | | | | | | | | | |
| **Task**<br>10. Establish two way communication with hospital and home care that services have been initiated when patient discharged.<br>• Home care will also report back to the hospital regarding patients referred but not admitted to home health because the patient cancelled once they got home or they were not home/not found, etc.. | | | | | | | | | | |
| **Milestone #2**<br>Ensure home care staff have knowledge and skills to identify and respond to patient risks for readmission, as well as to support evidence-based medicine and chronic care management. | | | | | | | | | | |
| **Task**<br>Staff trained on care model, specific to:<br>- patient risks for readmission<br>- evidence-based preventive medicine<br>- chronic disease management | 0 | 0 | 0 | 0 | 1 | 2 | 3 | 5 | 5 | 5 |
| **Task**<br>Evidence-based guidelines for chronic-condition management implemented. | | | | | | | | | | |
| **Task**<br>1. Asses current tools and educational offering utilized by home care staff for identification of changes in condition, chronic disease management, etc | | | | | | | | | | |
| **Task**<br>2. Identify and obtain INTERACT-like tools that are needed to be used to educate home care | | | | | | | | | | |
| **Task**<br>3. Determine resources needed for training, such as modules, train the trainer methods or direct education | | | | | | | | | | |
| **Task**<br>4. Develop education plan and timeline for home care staff | | | | | | | | | | |
| **Task**<br>5. Secure resources needed for training sessions, using INTERACT-like tools to supplement gaps in education needs | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>6. Train staff on chosen care model, focus on changes in patient condition, evidence based preventive medicine care coordination and chronic disease management | | | | | | | | | | |
| **Task**<br>7. Document, track and aggregate evaluations of all training sessions using a learning management software (LMS) tool provided by the PPS. | | | | | | | | | | |
| **Task**<br>8. Revise education methods as necessary to meet the needs of the participants | | | | | | | | | | |
| **Milestone #3**<br>Develop care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer. | | | | | | | | | | |
| **Task**<br>Care pathways and clinical tool(s) created to monitor chronically-ill patients. | | | | | | | | | | |
| **Task**<br>PPS has developed and implemented interventions aimed at avoiding eventual hospital transfer and has trained staff on use of interventions in alignment with the PPS strategic plan to monitor critically ill patients and avoid hospital readmission. | 0 | 0 | 0 | 0 | 2 | 5 | 8 | 12 | 12 | 12 |
| **Task**<br>1. Using INTERACT-like tools develop care pathways for home care to monitor chronically-ill patients | | | | | | | | | | |
| **Task**<br>2. Through provider agreements, include guidance on when to notify primary care physician of change in condition | | | | | | | | | | |
| **Task**<br>3. Focus on care pathways with INTERACT-like tools on at home care level of recognition<br>• Acute mental status change<br>• Changes in vital signs<br>• Change in behavior<br>• Observed change in fluid intake and output<br>• Fever or change in temperature<br>• Nausea, vomiting, diarrhea<br>• Symptoms of lower respiratory illness<br>• Symptoms of CHF<br>• Symptoms of UTI | | | | | | | | | | |
| **Task**<br>4. Work with IT resources through the PPS to help track | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| readmissions | | | | | | | | | | |
| **Task** 5. Establish quality review methodology for review of care pathways, adapt to improve outcomes | | | | | | | | | | |
| **Task** 6. Link to interventions developed with other projects, such as care transition project, integration of behavioral health & palliative care | | | | | | | | | | |
| **Task** 7. Pilot EHR programs and software solutions to home care teams, work with IT consultants to assess feasibility of piloting programs | | | | | | | | | | |
| **Task** 8. Present recommendations to the Clinical Integration and Quality committee of the PPS on project methodology | | | | | | | | | | |
| **Task** 9. Train staff on guidelines | | | | | | | | | | |
| **Milestone #4** Educate all staff on care pathways and INTERACT-like principles. | | | | | | | | | | |
| **Task** Training program for all home care staff established, which encompasses care pathways and INTERACT-like principles. | 0 | 0 | 0 | 0 | 1 | 2 | 3 | 5 | 5 | 5 |
| **Task** 1. Develop training programs for home care staff based on INTERACT-like tools. Provide education to PCP and their staff on the use of home care services and pathways utilized to prevent hospitalization and avoiding readmission | | | | | | | | | | |
| **Task** 2. Develop learning programs for home care staff, including early warning tools and communication tools | | | | | | | | | | |
| **Task** 3. Include education for home care staff on needs of special populations, including intellectually and developmentally disabled members | | | | | | | | | | |
| **Task** 4. Conduct initial and annual training sessions for home care staff | | | | | | | | | | |
| **Task** 5. Collaborate with Workforce Committee of the PPS to develop training programs for new hires, retrained and/or re-deployed staff. | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task** 6. Maintain list of trainings, participants, evaluations and curriculum revisions through PPS based Learning Management System ( LMS) tool | | | | | | | | | | |
| **Task** 7. Develop plan with cultural competency and health literacy taskforce education specific to cultural differences and end of life care | | | | | | | | | | |
| **Task** 8. Evaluate, review and update training materials as needed and/or as recommended by Clinical Integration and Quality committee | | | | | | | | | | |
| **Milestone #5** Develop Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care. | | | | | | | | | | |
| **Task** Advance Care Planning tools incorporated into program (as evidenced by policies and procedures). | | | | | | | | | | |
| **Task** 1. Identify Advance Care planning tools including communication guide, tracking tool, comfort order set, and educational materials for patient and families. Provide education to staff on advance care planning, MOLST, and palliative care. Include subject matter experts such as Hospice Teams to assist in educational sessions | | | | | | | | | | |
| **Task** 2. Assess current state tools that are available to patients and families | | | | | | | | | | |
| **Task** 3. Adopt Advance Care planning tools to supplement existing tools for patients and families. | | | | | | | | | | |
| **Task** 4. Use INTERACT-like principals to address options for palliative and end of life care if appropriate. | | | | | | | | | | |
| **Task** 5. Script discussions with patients and families regarding accessibility to forms | | | | | | | | | | |
| **Task** 6. Explore innovative ways to identify tools, ie: magnetize, ID alerts, software apps | | | | | | | | | | |
| **Task** 7. Coordinate with Cultural Competency and Health Literacy task force of the PPS inclusion of age appropriate, culturally sensitive care planning tools | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task** 8. Track, trend and benchmark defined measures related to INTERACT-like advance care planning tools. | | | | | | | | | | |
| **Task** 9. Identify areas for improvement if necessary and report through the Clinical Integration and Quality Committee care improvement activities | | | | | | | | | | |
| **Milestone #6** Create coaching program to facilitate and support implementation. | | | | | | | | | | |
| **Task** INTERACT-like coaching program has been established for all home care and Rapid Response Team staff. | 0 | 0 | 0 | 0 | 1 | 2 | 3 | 5 | 5 | 5 |
| **Task** 1. Identify INTERACT-like coaching program for the home care and expedited discharge teams | | | | | | | | | | |
| **Task** 2. Identify champion(s) for the program at sites to motivate and assist in coordination of the program. | | | | | | | | | | |
| **Task** 3. Identify coaching tools on INTERACT-like to guide implementation Use communication tools that support engagement with hospitals and home care agencies | | | | | | | | | | |
| **Task** 4. Schedule and conduct strategic meetings with hospitals and home care agencies to evaluate development, implementation and outcomes of programs | | | | | | | | | | |
| **Task** 5. Integrate coaching program with overlapping projects of the PPS, including Care Transitions project (2.b.iv) and ED Care Triage project (2.b.iii). | | | | | | | | | | |
| **Task** 6. Integrate technology platforms and solutions recommended by the PPS IT committee to support program implementation. | | | | | | | | | | |
| **Task** 7. Implement quality improvement cycle to evaluate outcomes through metrics | | | | | | | | | | |
| **Task** 8. Use quality improvement tools to coach home care education and care process improvements. | | | | | | | | | | |
| **Milestone #7** Educate patient and family/caretakers, to facilitate participation in planning of care. | | | | | | | | | | |
| **Task** | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| Patients and families educated and involved in planning of care using INTERACT-like principles. | | | | | | | | | | |
| **Task** 1. Collaborate with education vendors to purchase patient and family focused education | | | | | | | | | | |
| **Task** 2. Assess what is currently being used by health care workers in the home environment | | | | | | | | | | |
| **Task** 3. Include patient and family education components with INTERACT-like solutions. Identify, develop patient/family education tools that address health literacy/cultural sensitivity & utilize technology such as videos, tablets to address principles of adult education | | | | | | | | | | |
| **Task** 4. Patient and family education sections to include education for family members to recognize change in condition and communication avenues regarding change. | | | | | | | | | | |
| **Task** 5. Include discussions with patient and families risks and benefits of hospitalization using INTERACT-like advance care planning tools. | | | | | | | | | | |
| **Task** 6. Establish a patient and family-oriented teach back program for early identification of adverse effects of medication | | | | | | | | | | |
| **Task** 7. Establish a patient and family-oriented teach back program for understanding of early comfort measures | | | | | | | | | | |
| **Task** 8. Establish quality review methods through the Clinical Integration and Quality committee of the PPS to evaluate patient hospital readmission for those who have received the aforementioned training, and use root cause analysis to revise methodology as necessary to enhance participation. | | | | | | | | | | |
| **Task** 9. As sites are phased in, track and evaluate programs at each site using rapid cycle team evaluation techniques | | | | | | | | | | |
| **Task** 10. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | | | | | | | | | | |
| **Task** 11. Communicate with hospitals and home care agencies level of success of program quarterly | | | | | | | | | | |
| **Milestone #8** Integrate primary care, behavioral health, pharmacy, and other | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| services into the model in order to enhance coordination of care and medication management. | | | | | | | | | | |
| **Task** All relevant services (physical, behavioral, pharmacological) integrated into care and medication management model. | | | | | | | | | | |
| **Task** 1. Identify INTERACT-like processes that include medication management for hospital to home care collaboration. | | | | | | | | | | |
| **Task** 2. Explore pharmacy support for homecare when evaluating care models | | | | | | | | | | |
| **Task** 3. Assess providers and entities that use INTERACT-like interventions in practices, including primary care, PCMH, hospitals, mental health providers, home health organizations, Health home, pharmacies, community based organizations, etc. | | | | | | | | | | |
| **Task** 4. Include members of all provider types on project teams | | | | | | | | | | |
| **Task** 5. Develop future state care coordination and medication management model | | | | | | | | | | |
| **Task** 6. Use home care tools, including advance care planning, monitored medication dispensers, medication reconciliation worksheets, early change in condition tools, SBAR communication tools that reflect all relevant services | | | | | | | | | | |
| **Task** 7. Work with project managers/directors, leads and champions of other projects within the PPS, and PPS leadership to establish, strengthen and enhance integration of projects to include INTERACT-like tools for home health care. | | | | | | | | | | |
| **Task** 8. Extend educational sessions to providers and entities on care and medication model | | | | | | | | | | |
| **Task** 9. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | | | | | | | | | | |
| **Task** 10. Track and evaluate programs at each site using rapid cycle team evaluation techniques | | | | | | | | | | |
| **Task** 11. Consider pilot program on medication reconciliation with community resources and pharmacies for disposal, removal, and poly-pharmacy reconciliation | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Milestone #9** Utilize telehealth/telemedicine to enhance hospital-home care collaborations. | | | | | | | | | | |
| **Task** Telehealth/telemedicine program established to provide care transition services, prevent avoidable hospital use, and increase specialty expertise of PCPs and staff. | | | | | | | | | | |
| **Task** 1. Determine requirements and needs assessment for technology assisted services (telehealth/ telemedicine) program within the PPS | | | | | | | | | | |
| **Task** 2. Assess current telehealth/telemedicine use and other technical platforms in the PPS to evaluate opportunities. | | | | | | | | | | |
| **Task** 3. Update existing telehealth systems for more desired state of the art technology and expand best practices to enhance the use and unitization of telehealth for high risk patients | | | | | | | | | | |
| **Task** 4. Determine incremental IT needs and associated financial implications, including short-term solutions | | | | | | | | | | |
| **Task** 5. Establish a process for monitoring telehealth/telemedicine milestones and performance. | | | | | | | | | | |
| **Task** 6. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS. | | | | | | | | | | |
| **Task** 7. Consider piloting a telemedicine program for a specific high risk diagnosis and care pathway as identified in our Community Needs Assessment. Utilizing existing model / data from results of RCA's for readmissions. | | | | | | | | | | |
| **Task** 8. Data analysis will be shared with partners and Managed Care Organizations. | | | | | | | | | | |
| **Milestone #10** Utilize interoperable EHR to enhance communication and avoid medication errors and/or duplicative services. | | | | | | | | | | |
| **Task** Clinical Interoperability System in place for all participating providers. Usage documented by the identified care coordinators. | | | | | | | | | | |
| **Task** 1. Determine requirements for clinical interoperability system | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task** 2. Assess current EHR and other technical platforms in the PPS against these requirements | | | | | | | | | | |
| **Task** 3. Determine method to identify the best source for medication reconciliation | | | | | | | | | | |
| **Task** 4. Determine incremental IT needs and associated budget, including short-term solutions | | | | | | | | | | |
| **Task** 5. Establish a process for monitoring project milestones and performance. | | | | | | | | | | |
| **Task** 6. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS. | | | | | | | | | | |
| **Milestone #11** Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions. | | | | | | | | | | |
| **Task** Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders. | | | | | | | | | | |
| **Task** Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives. | | | | | | | | | | |
| **Task** PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics in Attachment J. | | | | | | | | | | |
| **Task** Service and quality outcome measures are reported to all stakeholders. | | | | | | | | | | |
| **Task** 1. Identify members of Clinical Integration and Quality committee, including project lead and teams from hospital and home care | | | | | | | | | | |
| **Task** 2. Incorporate existing quality improvement process from existing home care agencies | | | | | | | | | | |
| **Task** 3. Project committee benchmark, track and trend defined measures | | | | | | | | | | |
| **Task** 4. Develop process for rapid cycle improvement methodologies | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| focusing on root cause analysis (RCA) of hospital transfer Use INTERACT like tools, such as acute care transfer logs, to track and trend transfers | | | | | | | | | | |
| **Task** 5. Project lead/champions and other home health key stakeholders to aggregate data to summarize finding and trends from individual hospital transfers into quality improvement tool on monthly basis | | | | | | | | | | |
| **Task** 6. Quality improvement committee members to recommend outcome improvement efforts based on trending data and action plans related to applicable metrics | | | | | | | | | | |
| **Task** 7. Track and evaluate programs at each site using rapid cycle team evaluation techniques and report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | | | | | | | | | | |
| **Milestone #12** Use EHRs and other technical platforms to track all patients engaged in the project. | | | | | | | | | | |
| **Task** PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. | | | | | | | | | | |
| **Task** 1. Determine requirements for identification of targeted patients and tracking actively engaged patients per state-provided specifications for the DSRIP program. | | | | | | | | | | |
| **Task** 2. Review strategies and tools needed to promote DSRIP specific Patient Engagement | | | | | | | | | | |
| **Task** 3. Working with the project team document current and future state work flow in addition to capturing manual solutions in place at this time | | | | | | | | | | |
| **Task** 4. Monitor partnering sites that are unable to meet metrics and goals and develop process improving plan with AFBHC leadership team to gain full attainment of partner contract requirements | | | | | | | | | | |
| **Task** 5. Create a gap analysis based on the work flow analysis to determine incremental IT needs and associated budget, including short-term manual solutions | | | | | | | | | | |
| **Task** 6. Identify prioritization of systems to build or associated change | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| with separate work streams focused on implementing new Electronic Health Record Systems vs. RHIO connectivity based on the project needs and associated providers' needs | | | | | | | | | | |
| **Task**<br>7. Develop a roll-out plan for systems to achieve clinical data sharing, including a training plan to support the successful implementation of new platforms and processes | | | | | | | | | | |
| **Task**<br>8. Establish a process for monitoring project milestones and performance | | | | | | | | | | |
| **Task**<br>9. Where electronic functionality is not yet ready, implement alternate in the interim and track conversion to electronic systems. | | | | | | | | | | |
| **Task**<br>10. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS. | | | | | | | | | | |
| **Task**<br>11. Develop a process for determining how success will be measured that incorporates feedback from providers and other key users of IT, including financial and patient engagement impact and risks. | | | | | | | | | | |

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Milestone #1**<br>Assemble Rapid Response Teams (hospital/home care) to facilitate patient discharge to home and assure needed home care services are in place, including, if appropriate, hospice. | | | | | | | | | | |
| **Task**<br>Rapid Response Teams are facilitating hospital-home care collaboration, with procedures and protocols for:<br>- discharge planning<br>- discharge facilitation<br>- confirmation of home care services | | | | | | | | | | |
| **Task**<br>1. Identify project lead at PPS level | | | | | | | | | | |
| **Task**<br>2. Form project implementation teams at each site, including case management and home care administrative and front line staff and PPS providers | | | | | | | | | | |
| **Task**<br>3. St Mary's Hospital, Amsterdam; Ellis Hospital; St Peter's Hospital; Samaritan Hospital, St Mary's Hospital, Troy; and | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| Albany Memorial Hospital partner hospitals will participate in development of early discharge identification process for home care service integration with Community Health Center, The Eddy and Visiting Nurse Service of Schenectady. (*Expedited Discharge Team [EDT] in lieu of Rapid Response Team name) | | | | | | | | | | |
| **Task**<br>4. Include existing Coleman trained care transitions coaches (CTC) to assist in development of discharge teams | | | | | | | | | | |
| **Task**<br>5. Complete a current state baseline of discharge processes, home care integration, palliative care and hospice involvement. | | | | | | | | | | |
| **Task**<br>6. Define future state for the hospital to home-care collaboration programs with INTERACT-like techniques<br>• Include collaboration during hospital visit to include home care liaison for greater acceptance of services being offered | | | | | | | | | | |
| **Task**<br>7. Integrate behavioral health concerns into process, including screening tools and appropriate referrals | | | | | | | | | | |
| **Task**<br>8. Present recommendations and periodic updates to the Clinical Integration and Quality committee of the PPS on project methodology | | | | | | | | | | |
| **Task**<br>9. Implement clinical guidelines for hospital discharges to home care services. | | | | | | | | | | |
| **Task**<br>10. Establish two way communication with hospital and home care that services have been initiated when patient discharged.<br>• Home care will also report back to the hospital regarding patients referred but not admitted to home health because the patient cancelled once they got home or they were not home/not found, etc.. | | | | | | | | | | |
| **Milestone #2**<br>Ensure home care staff have knowledge and skills to identify and respond to patient risks for readmission, as well as to support evidence-based medicine and chronic care management. | | | | | | | | | | |
| **Task**<br>Staff trained on care model, specific to:<br>- patient risks for readmission<br>- evidence-based preventive medicine<br>- chronic disease management | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 |
| **Task**<br>Evidence-based guidelines for chronic-condition management | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| implemented. | | | | | | | | | | |
| **Task**<br>1. Asses current tools and educational offering utilized by home care staff for identification of changes in condition, chronic disease management, etc | | | | | | | | | | |
| **Task**<br>2. Identify and obtain INTERACT-like tools that are needed to be used to educate home care | | | | | | | | | | |
| **Task**<br>3. Determine resources needed for training, such as modules, train the trainer methods or direct education | | | | | | | | | | |
| **Task**<br>4. Develop education plan and timeline for home care staff | | | | | | | | | | |
| **Task**<br>5. Secure resources needed for training sessions, using INTERACT-like tools to supplement gaps in education needs | | | | | | | | | | |
| **Task**<br>6. Train staff on chosen care model, focus on changes in patient condition, evidence based preventive medicine care coordination and chronic disease management | | | | | | | | | | |
| **Task**<br>7. Document, track and aggregate evaluations of all training sessions using a learning management software (LMS) tool provided by the PPS. | | | | | | | | | | |
| **Task**<br>8. Revise education methods as necessary to meet the needs of the participants | | | | | | | | | | |
| **Milestone #3**<br>Develop care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer. | | | | | | | | | | |
| **Task**<br>Care pathways and clinical tool(s) created to monitor chronically-ill patients. | | | | | | | | | | |
| **Task**<br>PPS has developed and implemented interventions aimed at avoiding eventual hospital transfer and has trained staff on use of interventions in alignment with the PPS strategic plan to monitor critically ill patients and avoid hospital readmission. | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 |
| **Task**<br>1. Using INTERACT-like tools develop care pathways for home care to monitor chronically-ill patients | | | | | | | | | | |
| **Task**<br>2. Through provider agreements, include guidance on when to | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| notify primary care physician of change in condition | | | | | | | | | | |
| **Task**<br>3. Focus on care pathways with INTERACT-like tools on at home care level of recognition<br>• Acute mental status change<br>• Changes in vital signs<br>• Change in behavior<br>• Observed change in fluid intake and output<br>• Fever or change in temperature<br>• Nausea, vomiting, diarrhea<br>• Symptoms of lower respiratory illness<br>• Symptoms of CHF<br>• Symptoms of UTI | | | | | | | | | | |
| **Task**<br>4. Work with IT resources through the PPS to help track readmissions | | | | | | | | | | |
| **Task**<br>5. Establish quality review methodology for review of care pathways, adapt to improve outcomes | | | | | | | | | | |
| **Task**<br>6. Link to interventions developed with other projects, such as care transition project, integration of behavioral health & palliative care | | | | | | | | | | |
| **Task**<br>7. Pilot EHR programs and software solutions to home care teams, work with IT consultants to assess feasibility of piloting programs | | | | | | | | | | |
| **Task**<br>8. Present recommendations to the Clinical Integration and Quality committee of the PPS on project methodology | | | | | | | | | | |
| **Task**<br>9. Train staff on guidelines | | | | | | | | | | |
| **Milestone #4**<br>Educate all staff on care pathways and INTERACT-like principles. | | | | | | | | | | |
| **Task**<br>Training program for all home care staff established, which encompasses care pathways and INTERACT-like principles. | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 |
| **Task**<br>1. Develop training programs for home care staff based on INTERACT-like tools.<br>Provide education to PCP and their staff on the use of home care | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| services and pathways utilized to prevent hospitalization and avoiding readmission | | | | | | | | | | |
| **Task** 2. Develop learning programs for home care staff, including early warning tools and communication tools | | | | | | | | | | |
| **Task** 3. Include education for home care staff on needs of special populations, including intellectually and developmentally disabled members | | | | | | | | | | |
| **Task** 4. Conduct initial and annual training sessions for home care staff | | | | | | | | | | |
| **Task** 5. Collaborate with Workforce Committee of the PPS to develop training programs for new hires, retrained and/or re-deployed staff. | | | | | | | | | | |
| **Task** 6. Maintain list of trainings, participants, evaluations and curriculum revisions through PPS based Learning Management System ( LMS) tool | | | | | | | | | | |
| **Task** 7. Develop plan with cultural competency and health literacy taskforce education specific to cultural differences and end of life care | | | | | | | | | | |
| **Task** 8. Evaluate, review and update training materials as needed and/or as recommended by Clinical Integration and Quality committee | | | | | | | | | | |
| **Milestone #5** Develop Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care. | | | | | | | | | | |
| **Task** Advance Care Planning tools incorporated into program (as evidenced by policies and procedures). | | | | | | | | | | |
| **Task** 1. Identify Advance Care planning tools including communication guide, tracking tool, comfort order set, and educational materials for patient and families. Provide education to staff on advance care planning, MOLST, and palliative care. Include subject matter experts such as Hospice Teams to assist in educational sessions | | | | | | | | | | |
| **Task** 2. Assess current state tools that are available to patients and families | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task** 3. Adopt Advance Care planning tools to supplement existing tools for patients and families. | | | | | | | | | | |
| **Task** 4. Use INTERACT-like principals to address options for palliative and end of life care if appropriate. | | | | | | | | | | |
| **Task** 5. Script discussions with patients and families regarding accessibility to forms | | | | | | | | | | |
| **Task** 6. Explore innovative ways to identify tools, ie: magnetize, ID alerts, software apps | | | | | | | | | | |
| **Task** 7. Coordinate with Cultural Competency and Health Literacy task force of the PPS inclusion of age appropriate, culturally sensitive care planning tools | | | | | | | | | | |
| **Task** 8. Track, trend and benchmark defined measures related to INTERACT-like advance care planning tools. | | | | | | | | | | |
| **Task** 9. Identify areas for improvement if necessary and report through the Clinical Integration and Quality Committee care improvement activities | | | | | | | | | | |
| **Milestone #6** Create coaching program to facilitate and support implementation. | | | | | | | | | | |
| **Task** INTERACT-like coaching program has been established for all home care and Rapid Response Team staff. | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 |
| **Task** 1. Identify INTERACT-like coaching program for the home care and expedited discharge teams | | | | | | | | | | |
| **Task** 2. Identify champion(s) for the program at sites to motivate and assist in coordination of the program. | | | | | | | | | | |
| **Task** 3. Identify coaching tools on INTERACT-like to guide implementation Use communication tools that support engagement with hospitals and home care agencies | | | | | | | | | | |
| **Task** 4. Schedule and conduct strategic meetings with hospitals and home care agencies to evaluate development, implementation and outcomes of programs | | | | | | | | | | |
| **Task** | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| 5. Integrate coaching program with overlapping projects of the PPS, including Care Transitions project (2.b.iv) and ED Care Triage project (2.b.iii). | | | | | | | | | | |
| **Task**<br>6. Integrate technology platforms and solutions recommended by the PPS IT committee to support program implementation. | | | | | | | | | | |
| **Task**<br>7. Implement quality improvement cycle to evaluate outcomes through metrics | | | | | | | | | | |
| **Task**<br>8. Use quality improvement tools to coach home care education and care process improvements. | | | | | | | | | | |
| **Milestone #7**<br>Educate patient and family/caretakers, to facilitate participation in planning of care. | | | | | | | | | | |
| **Task**<br>Patients and families educated and involved in planning of care using INTERACT-like principles. | | | | | | | | | | |
| **Task**<br>1. Collaborate with education vendors to purchase patient and family focused education | | | | | | | | | | |
| **Task**<br>2. Assess what is currently being used by health care workers in the home environment | | | | | | | | | | |
| **Task**<br>3. Include patient and family education components with INTERACT-like solutions. Identify, develop patient/family education tools that address health literacy/cultural sensitivity & utilize technology such as videos, tablets to address principles of adult education | | | | | | | | | | |
| **Task**<br>4. Patient and family education sections to include education for family members to recognize change in condition and communication avenues regarding change. | | | | | | | | | | |
| **Task**<br>5. Include discussions with patient and families risks and benefits of hospitalization using INTERACT-like advance care planning tools. | | | | | | | | | | |
| **Task**<br>6. Establish a patient and family-oriented teach back program for early identification of adverse effects of medication | | | | | | | | | | |
| **Task**<br>7. Establish a patient and family-oriented teach back program for understanding of early comfort measures | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>8. Establish quality review methods through the Clinical Integration and Quality committee of the PPS to evaluate patient hospital readmission for those who have received the aforementioned training, and use root cause analysis to revise methodology as necessary to enhance participation. | | | | | | | | | | |
| **Task**<br>9. As sites are phased in, track and evaluate programs at each site using rapid cycle team evaluation techniques | | | | | | | | | | |
| **Task**<br>10. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | | | | | | | | | | |
| **Task**<br>11. Communicate with hospitals and home care agencies level of success of program quarterly | | | | | | | | | | |
| **Milestone #8**<br>Integrate primary care, behavioral health, pharmacy, and other services into the model in order to enhance coordination of care and medication management. | | | | | | | | | | |
| **Task**<br>All relevant services (physical, behavioral, pharmacological) integrated into care and medication management model. | | | | | | | | | | |
| **Task**<br>1. Identify INTERACT-like processes that include medication management for hospital to home care collaboration. | | | | | | | | | | |
| **Task**<br>2. Explore pharmacy support for homecare when evaluating care models | | | | | | | | | | |
| **Task**<br>3. Assess providers and entities that use INTERACT-like interventions in practices, including primary care, PCMH, hospitals, mental health providers, home health organizations, Health home, pharmacies, community based organizations, etc. | | | | | | | | | | |
| **Task**<br>4. Include members of all provider types on project teams | | | | | | | | | | |
| **Task**<br>5. Develop future state care coordination and medication management model | | | | | | | | | | |
| **Task**<br>6. Use home care tools, including advance care planning, monitored medication dispensers, medication reconciliation worksheets, early change in condition tools, SBAR communication tools that reflect all relevant services | | | | | | | | | | |
| **Task**<br>7. Work with project managers/directors, leads and champions of | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| other projects within the PPS, and PPS leadership to establish, strengthen and enhance integration of projects to include INTERACT-like tools for home health care. | | | | | | | | | | |
| **Task** 8. Extend educational sessions to providers and entities on care and medication model | | | | | | | | | | |
| **Task** 9. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | | | | | | | | | | |
| **Task** 10. Track and evaluate programs at each site using rapid cycle team evaluation techniques | | | | | | | | | | |
| **Task** 11. Consider pilot program on medication reconciliation with community resources and pharmacies for disposal, removal, and poly-pharmacy reconciliation | | | | | | | | | | |
| **Milestone #9** Utilize telehealth/telemedicine to enhance hospital-home care collaborations. | | | | | | | | | | |
| **Task** Telehealth/telemedicine program established to provide care transition services, prevent avoidable hospital use, and increase specialty expertise of PCPs and staff. | | | | | | | | | | |
| **Task** 1. Determine requirements and needs assessment for technology assisted services (telehealth/ telemedicine) program within the PPS | | | | | | | | | | |
| **Task** 2. Assess current telehealth/telemedicine use and other technical platforms in the PPS to evaluate opportunities. | | | | | | | | | | |
| **Task** 3. Update existing telehealth systems for more desired state of the art technology and expand best practices to enhance the use and unitization of telehealth for high risk patients | | | | | | | | | | |
| **Task** 4. Determine incremental IT needs and associated financial implications, including short-term solutions | | | | | | | | | | |
| **Task** 5. Establish a process for monitoring telehealth/telemedicine milestones and performance. | | | | | | | | | | |
| **Task** 6. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS. | | | | | | | | | | |
| **Task** | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| 7. Consider piloting a telemedicine program for a specific high risk diagnosis and care pathway as identified in our Community Needs Assessment. Utilizing existing model / data from results of RCA's for readmissions. | | | | | | | | | | |
| **Task**<br>8. Data analysis will be shared with partners and Managed Care Organizations. | | | | | | | | | | |
| **Milestone #10**<br>Utilize interoperable EHR to enhance communication and avoid medication errors and/or duplicative services. | | | | | | | | | | |
| **Task**<br>Clinical Interoperability System in place for all participating providers. Usage documented by the identified care coordinators. | | | | | | | | | | |
| **Task**<br>1. Determine requirements for clinical interoperability system | | | | | | | | | | |
| **Task**<br>2. Assess current EHR and other technical platforms in the PPS against these requirements | | | | | | | | | | |
| **Task**<br>3. Determine method to identify the best source for medication reconciliation | | | | | | | | | | |
| **Task**<br>4. Determine incremental IT needs and associated budget, including short-term solutions | | | | | | | | | | |
| **Task**<br>5. Establish a process for monitoring project milestones and performance. | | | | | | | | | | |
| **Task**<br>6. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS. | | | | | | | | | | |
| **Milestone #11**<br>Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions. | | | | | | | | | | |
| **Task**<br>Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders. | | | | | | | | | | |
| **Task**<br>Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives. | | | | | | | | | | |
| **Task** | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics in Attachment J. | | | | | | | | | | |
| **Task** Service and quality outcome measures are reported to all stakeholders. | | | | | | | | | | |
| **Task** 1. Identify members of Clinical Integration and Quality committee, including project lead and teams from hospital and home care | | | | | | | | | | |
| **Task** 2. Incorporate existing quality improvement process from existing home care agencies | | | | | | | | | | |
| **Task** 3. Project committee benchmark, track and trend defined measures | | | | | | | | | | |
| **Task** 4. Develop process for rapid cycle improvement methodologies focusing on root cause analysis (RCA) of hospital transfer Use INTERACT like tools, such as acute care transfer logs, to track and trend transfers | | | | | | | | | | |
| **Task** 5. Project lead/champions and other home health key stakeholders to aggregate data to summarize finding and trends from individual hospital transfers into quality improvement tool on monthly basis | | | | | | | | | | |
| **Task** 6. Quality improvement committee members to recommend outcome improvement efforts based on trending data and action plans related to applicable metrics | | | | | | | | | | |
| **Task** 7. Track and evaluate programs at each site using rapid cycle team evaluation techniques and report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | | | | | | | | | | |
| **Milestone #12** Use EHRs and other technical platforms to track all patients engaged in the project. | | | | | | | | | | |
| **Task** PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. | | | | | | | | | | |
| **Task** 1. Determine requirements for identification of targeted patients and tracking actively engaged patients per state-provided specifications for the DSRIP program. | | | | | | | | | | |
| **Task** 2. Review strategies and tools needed to promote DSRIP | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| specific Patient Engagement | | | | | | | | | | |
| **Task** 3. Working with the project team document current and future state work flow in addition to capturing manual solutions in place at this time | | | | | | | | | | |
| **Task** 4. Monitor partnering sites that are unable to meet metrics and goals and develop process improving plan with AFBHC leadership team to gain full attainment of partner contract requirements | | | | | | | | | | |
| **Task** 5. Create a gap analysis based on the work flow analysis to determine incremental IT needs and associated budget, including short-term manual solutions | | | | | | | | | | |
| **Task** 6. Identify prioritization of systems to build or associated change with separate work streams focused on implementing new Electronic Health Record Systems vs. RHIO connectivity based on the project needs and associated providers' needs | | | | | | | | | | |
| **Task** 7. Develop a roll-out plan for systems to achieve clinical data sharing, including a training plan to support the successful implementation of new platforms and processes | | | | | | | | | | |
| **Task** 8. Establish a process for monitoring project milestones and performance | | | | | | | | | | |
| **Task** 9. Where electronic functionality is not yet ready, implement alternate in the interim and track conversion to electronic systems. | | | | | | | | | | |
| **Task** 10. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS. | | | | | | | | | | |
| **Task** 11. Develop a process for determining how success will be measured that incorporates feedback from providers and other key users of IT, including financial and patient engagement impact and risks. | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Prescribed Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|

No Records Found

### Prescribed Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|
| Assemble Rapid Response Teams (hospital/home care) to facilitate patient discharge to home and assure needed home care services are in place, including, if appropriate, hospice. | Tasks 2 and 4 originally dated 12/31/2015 have been moved to 3/31/2016 to reflect the ongoing nature of the work. |
| Ensure home care staff have knowledge and skills to identify and respond to patient risks for readmission, as well as to support evidence-based medicine and chronic care management. | |
| Develop care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer. | |
| Educate all staff on care pathways and INTERACT-like principles. | |
| Develop Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care. | |
| Create coaching program to facilitate and support implementation. | |
| Educate patient and family/caretakers, to facilitate participation in planning of care. | |
| Integrate primary care, behavioral health, pharmacy, and other services into the model in order to enhance coordination of care and medication management. | |
| Utilize telehealth/telemedicine to enhance hospital-home care collaborations. | |
| Utilize interoperable EHR to enhance communication and avoid medication errors and/or duplicative services. | |
| Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions. | |
| Use EHRs and other technical platforms to track all patients engaged in the project. | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Milestone Review Status

| Milestone # | Review Status | IA Formal Comments |
|---|---|---|
| **Milestone #1** | Pass & Ongoing | |
| **Milestone #2** | Pass & Ongoing | |
| **Milestone #3** | Pass & Ongoing | |
| **Milestone #4** | Pass & Ongoing | |
| **Milestone #5** | Pass & Ongoing | |
| **Milestone #6** | Pass & Ongoing | |
| **Milestone #7** | Pass & Ongoing | |
| **Milestone #8** | Pass & Ongoing | |
| **Milestone #9** | Pass & Ongoing | |
| **Milestone #10** | Pass & Ongoing | |
| **Milestone #11** | Pass & Ongoing | |
| **Milestone #12** | Pass & Ongoing | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 2.b.viii.4 - PPS Defined Milestones

**Instructions :**

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for PPS-defined milestones.

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|

No Records Found

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC  (PPS ID:3)

**IPQR Module 2.b.viii.5 - IA Monitoring**

**Instructions :**

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Project 2.d.i – Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care

#### IPQR Module 2.d.i.1 - Major Risks to Implementation and Mitigation Strategies

**Instructions :**

Please describe what the major risks are for this project, as well as the actions you plan to take to mitigate them.

As patient engagement in the health system grows, utilization of services will increase. The PPS must have the primary care capacity to absorb the targeted population. To mitigate this risk, the Workforce committee will track supply & demand for PCP to identify gaps, assess geographic need & recruit/place physicians in shortage areas. Demand for PCP will be coordinated with Project 2.b.iii. The PPS will recruit primary care NPs & explore retraining RNs to pursue advanced practice credentials in primary care. Successful mitigation will be reflected in supply to demand match.
There are many IT Risks, such as data interoperability using multiple vendors that may not support existing standards- the risk mitigation strategy is to engage vendors early & determine supplemental solutions if available. The RHIO (the expected interoperable clinical platform) has expressed limitations on data sharing per NY state policies, working with EHR vendors to achieve data sharing & balancing DSRIP needs with existing commitments. Population Health IT (PHIT) systems & tools are required & delay to PHIT implementation delays the projects & risks not meeting speed/scale requirements. PHIT depends on sufficient capital funding from NY state & delay in capital release will delay the rollout. The PPS will work with the RHIO, accelerate implementation of PHIT interoperability, use alternate methods where EHRs & PHIT tool functionality aren't ready & work with NY to ensure capital is given in sufficient time.
Due to the transient nature of the target population, one risk is initiating activation activities on people who are lost to follow-up. Patient dropouts before the end of the performance period will negatively impact target implementation. To mitigate this risk, the PPS will develop specific client plans depending on engagement level. The PPS will address identified socio-economic barriers by linking to appropriate CBOs to meet basic needs (housing resources, food banks, transportation). Protocols for recovering dropouts will be created to document initial engagement. There are high rates of chronic disease, PQI & PPV in the PPS. A portion of unmet needs among the low income population is related to lack of engagement in disease management. The project will establish a PPS-administered chronic disease management program to extend the reach of self-management educational opportunities in times, places & languages that meet the population's needs. With the Cultural Competency Task Force, the project will train Community Health Workers (CHW) & make efforts to establish them within neighborhoods where they live. Outreach workers will have cultural competency/health literacy training to ensure cultural & linguistically appropriate interactions with the population. Successful mitigation will be reflected in number of persons engaged, a shift in the cohort to higher levels of engagement over time & low dropout rates.
Another risk is the ability to accurately track progress in patient engagement levels for the population at various levels & achieve project milestones' time/scale. The transience of the target population risks engagement in self-management care & measuring engagement outcomes if patients don't adopt self-management recommendations. Strategies to reduce this risk are intertwined with other projects. The IT component will incorporate methods to record initial engagement with the population, either electronically or manually until PHIT is available in the PPS. The PPS will explore ways to engage CBOs & find IT solutions that make access to this population more efficient. Integrating IT into community health work will allow for annual alerts for patients who need reassessment. Compliance will be tracked annually & dashboards will be created to determine which patients have engaged with self-management vs. inability to track patients for follow-up.

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 2.d.i.2 - Patient Engagement Speed

**Instructions :**

Enter the number of patients actively engaged through the current quarter. The number entered into the "Patient Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for DY1 Q3 should include patients previously reported in DY1 Q2 plus new patients engaged in DY1 Q3. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

| Benchmarks | |
|---|---|
| **100% Actively Engaged By** | **Expected Patient Engagement** |
| DY3,Q4 | 14,715 |

| Patients Engaged to Date in Current DY | DY1,Q3 Patient Update | % of Semi-Annual Commitment To-Date | Semi-Annual Variance of Projected to Actual | % of Total Actively Engaged Patients To-Date |
|---|---|---|---|---|
| 0 | 2,051 | 49.11% | 2,125 | 13.94% |

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (4,176)

### Current File Uploads

| User ID | File Type | File Name | File Description | Upload Date |
|---|---|---|---|---|
| cdomeier | PAM Documentation | 3_PMDL3615_1_3_20160129160125_AFBHC_2.d.i_Patient_Registry_DY_1,_Q3.xlsx | Patient Registry of PAM surveys completed in DY 1, Q3 | 01/29/2016 04:02 PM |

**Narrative Text :**

For PPS to provide additional context regarding progress and/or updates to IA.

### Module Review Status

| Review Status | IA Formal Comments |
|---|---|
| Pass & Ongoing | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 2.d.i.3 - Prescribed Milestones

**Instructions :**

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for prescribed milestones. For milestones that are due and completed within the reporting period, documentation is required to provide evidence of project requirement achievement. Any explanations regarding altered or missed provider commitments should be included within the narrative box, not as text within uploaded documentation.

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| **Milestone #1** Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** Partnerships with CBOs to assist in patient "hot-spotting" and engagement efforts as evidenced by MOUs, contracts, letters of agreement or other partnership documentation. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 1. PPS will develop MOUs, contracts and letters of agreement to work in concert to identify and engage uninsured, low utilizers, under-utilizers of healthcare. Identified partners and CBO's will be located utilizing data from the DSRIP Community Needs Assessment and other organizations already working with the targeted population | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 2. PPS will contract with Insignia Healthcare where PAM tool data will be stored for PPS tracking and reporting | Project | | Completed | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 |
| **Task** 3. PPS Clinical Operations Team will provide CBOs and partners quarterly reports on PAM tool implementation and statistics | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 4. PPS will create and distribute "hot spot" poster maps to contracted partners and CBO's in this project by utilizing data from our DSRIP Community Needs Assessment and information provided by other community organizations such as HCDI (Healthy Capital District Initiative). PPS will abstract additional information based on the organization's current involvement in serving the population of interest. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>5. The PPS will work in concert with additional regional PPS' (Adirondack Health Institute and Albany Medical Center) where county cross over occurs to collaborate on a coordinated approach to launch Project 11 efforts | Project | | In Progress | 05/01/2015 | 03/31/2017 | 05/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #2**<br>Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>Patient Activation Measure(R) (PAM(R)) training team established. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>1. PPS will contract with Insignia to provide PAM training on engaging target populations | Project | | Completed | 05/01/2015 | 09/30/2015 | 05/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 |
| **Task**<br>2. PPS will elicit volunteers from partners and CBO's to assign PAM "train the trainer" champions | Project | | Completed | 05/01/2015 | 09/30/2015 | 05/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 |
| **Task**<br>3. Volunteer Champions will attend coordinated educational planning session with Insignia on July 16, 2015. | Project | | Completed | 06/01/2015 | 07/31/2015 | 06/01/2015 | 07/31/2015 | 09/30/2015 | DY1 Q2 |
| **Task**<br>4. Volunteer Champions will continue to attend additional training and webinars provided by Insignia to ensure consistent education on patient activation techniques and documentation requirements | Project | | In Progress | 08/01/2015 | 03/31/2016 | 08/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task**<br>5. PPS Project 11 Manager will develop and organize additional educational sessions across the PPS utilizing the train the trainer champions and track attendance | Project | | In Progress | 08/01/2015 | 03/31/2016 | 08/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task**<br>6. PPS Project 11 Manager will track individuals who attend Insignia PAM training and additional training sessions provided by Insignia | Project | | In Progress | 06/01/2015 | 03/31/2016 | 06/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task**<br>7. PPS Project 11 Manager will collaborate with additional PPS's, CBO's and partners to develop strategy to capture attributed populations that corresponds | Project | | In Progress | 06/01/2015 | 03/31/2016 | 06/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Milestone #3** | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas. | | | | | | | | | |
| **Task** Analysis to identify "hot spot" areas completed and CBOs performing outreach engaged. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 1. Create and distribute "hot spot" poster maps developed using data from our DSRIP Community Needs Assessment and other community organizations (HCDI-Healthy Capital District Initiative) based on their current involvement in serving the population of interest. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 2. Based on the above data, PPS will identify and partner with CBOs that are located in the "hot spot" areas. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 3. PPS will develop contracts with identified partners and CBOs to perform outreach and engagement efforts | Project | | In Progress | 07/01/2015 | 03/31/2017 | 07/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 4. Collaborate with hospital partners (St. Mary's Healthcare, St. Peter's Health Partners and Ellis Hospital) and partner CBOs (Community Health Center, Living Resources, Schenectady Visiting Nurses) that provide Charity Care to identify additional members for patient activation. | Project | | In Progress | 09/01/2015 | 03/31/2017 | 09/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 5. PPS will arrange for Project 11 retreat to assemble key stakeholders and Workforce Committee to review current hot spot data and determine if there are outlying gaps in the PPS region such as sub-cultures (Amish, Burmese, and Guyanese) that the PPS would need develop additional cultural sensitive plans on how to employ additional community outreach workers to assist in engagement activities. | Project | | In Progress | 09/01/2015 | 03/31/2017 | 09/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 6. Collaborate with Government Officials to acknowledge and decipher legal aspects of health care reform and assistance for illegal immigrants and populations/cultures that are not networked into mainstream society. | Project | | In Progress | 01/01/2016 | 03/31/2016 | 01/01/2016 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Milestone #4** | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| Survey the targeted population about healthcare needs in the PPS' region. | | | | | | | | | |
| **Task** Community engagement forums and other information-gathering mechanisms established and performed. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 1. Explore and assess a variety of venues and opportunities to survey the targeted population (e.g. health fairs, community events and forums, shelters, senior centers & church gatherings). | Project | | In Progress | 10/01/2015 | 03/31/2017 | 10/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 2. Contract with community assessment experts in developing a survey/questionnaire for participation. Ensure survey is developed based on the DSRIP Community Needs Assessment that is culturally, intellectually and linguistically suitable for participants to complete. | Project | | In Progress | 10/01/2015 | 03/31/2017 | 10/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 3. Investigate the potential to contract with professional facilitators to hold community engagement forums to attain first hand attitudes and knowledge regarding one's ability to access and participate in healthcare/self-management | Project | | In Progress | 10/01/2015 | 03/31/2017 | 10/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #5** Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** PPS Providers (located in "hot spot" areas) trained in patient activation techniques by "PAM(R) trainers". | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 1. Project Manager and Workforce Committee will develop educational tracking mechanisms to track all providers who receive training for reporting | Project | | In Progress | 07/01/2015 | 03/31/2017 | 07/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 2. The PPS Cultural Competency Taskforce will collaborate with Iroquois Healthcare Alliance to develop curriculum and training programs that will address patient activation techniques. | Project | | In Progress | 01/01/2016 | 03/31/2017 | 01/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 3. The PPS will offer a variety of venues (webinars, in-person, online) courses to enhance the availability of providers to receive | Project | | In Progress | 01/01/2016 | 03/31/2017 | 01/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| training. Continue to utilize volunteer PAM train the trainers to provide onsite training at provider sites. | | | | | | | | | |
| **Milestone #6**<br>Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10).<br>• This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member.<br>• Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>Procedures and protocols established to allow the PPS to work with the member's MCO and assigned PCP to help reconnect that beneficiary to his/her designated PCP. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>1. Engage with the 3 Lead Health Homes in the PPS (St. Mary's Healthcare, Care Central-Ellis & Samaritan) to determine if DEAA/BAA feasibility for the review of Health Home Assignment files that denotes an attributed member with their last 5 healthcare encounters. This would allow community outreach workers to reconnect members to their PCP, administer PAM activations tool and assist members with referrals to Health Home Care Management services and other entitlement needs | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>2. Evaluate how each MCO determines PCP selection or assignment for their members | Project | | In Progress | 10/01/2015 | 03/31/2016 | 10/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task**<br>3. Coordinate & contract with the three leading Health Homes and downstream care coordination agencies, within our PPS, to assist with proactive outreach activities and administration of the | Project | | In Progress | 01/01/2016 | 03/31/2017 | 01/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| PAM assessment tool. | | | | | | | | | |
| **Task**<br>4. The PPS in concert with the MCO and partnering PCPs, will develop systematic protocol for access and read only rights to assess those designated as NU and LU of healthcare services to appropriate redirect care back to the designated/chosen provider of choice. | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #7**<br>Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>For each PAM(R) activation level, baseline and set intervals toward improvement determined at the beginning of each performance period (defined by the state). | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>1. Coordinate with the state on obtaining the method for establishing a baseline for each beneficiary based on network assessment | Project | | In Progress | 07/01/2015 | 03/31/2017 | 07/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>2. Leverage data gained from PAM tool and working with PCP's to establish baselines and intervals toward improvement for each performance period. | Project | | In Progress | 07/01/2015 | 03/31/2017 | 07/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>3. Develop plans to validate patient population and identify method to improvement engagement | Project | | In Progress | 09/01/2015 | 03/31/2017 | 09/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #8**<br>Include beneficiaries in development team to promote preventive care. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>Beneficiaries are utilized as a resource in program development and awareness efforts of preventive care services. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>1. Investigate the potential to contract with professional facilitators to hold community engagement forums. This will allow the PPS to collectively gain personal insight, beliefs and bias that beneficiaries may have that prevents them from | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| accessing needed healthcare | | | | | | | | | |
| **Task**<br>2. Collaborate with Cultural Broker Program developed through the Cultural Competency Taskforce | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>3. Utilize the AHRQ Working With Patient and Families as Advisers Implementation Handbook as a guide to develop a training program for adviser roles in the PPS | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #9**<br>Measure PAM(R) components, including:<br>• Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service.<br>• If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM(R) survey and designate a PAM(R) score.<br>• Individual member's score must be averaged to calculate a baseline measure for that year's cohort.<br>• The cohort must be followed for the entirety of the DSRIP program.<br>• On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation. • If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP.<br>• The PPS will NOT be responsible for assessing the patient via PAM(R) survey.<br>• PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes.<br>• Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>Performance measurement reports established, including but not | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| limited to:<br>- Number of patients screened, by engagement level<br>- Number of clinicians trained in PAM(R) survey implementation<br>- Number of patient: PCP bridges established<br>- Number of patients identified, linked by MCOs to which they are associated<br>- Member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis<br>- Member engagement lists to DOH (for NU & LU populations) on a monthly basis<br>- Annual report assessing individual member and the overall cohort's level of engagement | | | | | | | | | |
| **Task**<br>1. Utilize information from the PAM admin tool to collect required information and training logs to report against required metrics. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>2. Establish protocols and procedures for the community navigators to screen, assess, and administer the PAM® tool with eligible populations. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>3. Project 11 Team will develop pathways for community navigators to utilize when additional support is needed to assist the member through the various stages of the PAM assessment determination | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>4. Collaborate with Insignia to create and deliver reporting data. Provide feedback to PCPs and MCOs regarding level of engagement, reassessment and overall participation statistics | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>5. Identify process for connectivity to PCPs and PCMH providers through various avenues, including but not limited to direct conversation, IT solutions and other notification methods. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>6. Develop tool to be used by community navigators to assess cultural, linguistic and other needs that will enable placement with the most appropriate provider. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #10**<br>Increase the volume of non-emergent (primary, behavioral, | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| dental) care provided to UI, NU, and LU persons. | | | | | | | | | |
| **Task** Volume of non-emergent visits for UI, NU, and LU populations increased. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 1. The PPS Project Manager will work in conjunction with 2 b iii Project Lead to conduct a gap analysis and ongoing assessment of our PCMH partners to determine capacity and service specialty. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 2. Utilize the PPS website and provide a 'quick link' for community outreach workers to obtain current PCMH capacity and service information (ie: hours operation, accepting of new pts, etc) | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 3. Identify providers with open scheduling and capacity to accept returning patients, new patients or who need specialized service such as dentistry. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 4. Develop a referral process for community navigators to assess needs and link members to additional service providers. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #11** Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** Community navigators identified and contracted. | Provider | PAM(R) Providers | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including primary and preventive services), as well as patient education. | Provider | PAM(R) Providers | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 1. Collaborate with AFBHC leadership and CBOs who provide navigation services to develop contracts for outreach and engagement activities. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 2. Engage Workforce Committee to perform a gap analysis to determine workforce resources and training needs. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>9-24-15 Remediation Response<br>3. Working with our community partners to develop strategies to identify or engage potential navigators who represent the populations served. | Project | | In Progress | 09/24/2015 | 03/31/2017 | 09/24/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>9-24-15 Remediation response<br>4. Develop a broad approach to train navigators to administer the PAM tool. | Project | | In Progress | 09/24/2015 | 03/31/2017 | 09/24/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>9-24-15 Remediation Response<br>5. Identify the appropriate number and locations of navigators needed to utilize the PAM tool to meet the engagement commitments. Evaluate effectiveness of approach and address opportunities for improvement for work performed by the patient navigators. | Project | | In Progress | 09/24/2015 | 03/31/2017 | 09/24/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>9-24-15 Remediation Response<br>6. Develop a training strategy for established navigators that incorporates a periodic review of PAM administration techniques. Offer opportunities to leverage the experience of the successful navigators to partner with lower performing navigators.(i.e.: the rate of patients who decline opportunity to complete the PAM once the process is initiated). | Project | | In Progress | 09/24/2015 | 03/31/2017 | 09/24/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>9-24-15 Remediation Response<br>7. Based on CNA and workforce analysis, develop a methodology for piloting the PAM tool rollout, placement of trained navigators and expectations of engagement numbers a targeted locations. | Project | | In Progress | 09/24/2015 | 03/31/2016 | 09/24/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task**<br>9-24-15 Remediation Response<br>8. Develop process to identify areas for roll out of PAM tool and placement of trained navigators. | Project | | In Progress | 09/24/2015 | 03/31/2016 | 09/24/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task**<br>9-24-15 Remediation Response<br>9. Once the pilot rollout is achieved and redefined, if needed for improved outcomes, contrinue to roll out PAM engagements | Project | | In Progress | 09/24/2015 | 03/31/2017 | 09/24/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| sessions to achieve desired quotient of patient engagment. | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>10. Evaluate success of the program using workforce feedback, aggregation of engagment data and process improvements based on outcomes. | Project | | In Progress | 09/24/2015 | 03/31/2017 | 09/24/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>9-24-15 Remediation Response<br>11. Develop quarterly outcome dashboards and report to project teams, Clinical Integration and Quality Committee and Goverance committees to track and adjust program success when required. | Project | | In Progress | 09/24/2015 | 03/31/2017 | 09/24/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #12**<br>Develop a process for Medicaid recipients and project participants to report complaints and receive customer service. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>Policies and procedures for customer service complaints and appeals developed. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>1. The Alliance for Better Health Care has established an anonymous compliance hotline. Anyone may call the hotline or enter a concern on the web. The hotline is managed by an independent third party, Navex Global. Once a concern is received by the third party, a report is immediately sent to the Alliance's compliance officer. The compliance officer follows up on all concerns. A log is maintained of all concerns and the respective follow up actions. Hotline calls will be shared with the Audit and Compliance Committee quarterly. | Project | | In Progress | 08/01/2015 | 03/31/2017 | 08/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>2. Calls made directly to the Corporate Compliance Officer will establish an internal investigation and respond in an agreed-upon manner with the member. | Project | | In Progress | 08/01/2015 | 03/31/2017 | 08/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>9-24-15: Remediation Response<br>3. Policy and procedures for customer service complaints and appeals will be established & will, at a minimum, address the following key components:<br>a. Members will have the availability to call the PPS, leave any | Project | | In Progress | 09/24/2015 | 03/31/2017 | 09/24/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| questions/concerns/complaints regarding the NYS DOH DSRIP program on the 24 hour hotline or may submit a written complaint to the Corporate Compliance Officer for the Alliance for Better Health Care to 14 Columbia Circle , Albany NY 12203.<br><br>Themes for complaint resolution would include: Resolve issues where all information is available within the first call, if health is at risk within 48 hours of all information being available, otherwise within 7 days and not longer than 60. | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response:<br>The compliance committee will track, aggregate & report complaints & resolutions & outcomes to the Project lead (s) and Clinical Integration and Quality Committee to ensure optimal awareness and quality improvement. Quarterly outcome dashboards will be developed & reported to project teams, CQIC & governance committees to track & adjust program success, if required. | Project | | In Progress | 09/24/2015 | 03/31/2017 | 09/24/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #13**<br>Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R). | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>List of community navigators formally trained in the PAM(R). | Provider | PAM(R) Providers | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>1. Community navigators embedded in "hot spots" will receive PAM® training through the PPS-wide training team (see requirement #2) | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>2. Mechanism for tracking training of community navigators will be developed with our IT consultants | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #14**<br>Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** | Provider | PAM(R) Providers | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| Community navigators prominently placed (with high visibility) at appropriate locations within identified "hot spot" areas. | | | | | | | | | |
| **Task**<br>1. Based on the "hot spot" data, AFBHC will identify and partner with CBOs and ensure a presence at community events in these areas | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>2. Assess feasibility of co-locating community navigators at established Navigator Agency sites that provide facilitated insurance enrollment | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>3. Create a directory (map) of sites where community navigators are located across the 6-county region | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>9-24-15 Remediation Response<br>4. Develop a PPS-level strategy to screen person status (UI, NU, & LU) & collect contact information when they visit the PPS designated facility or "hot spot" area for health services or other social services. | Project | | In Progress | 09/24/2015 | 03/31/2016 | 09/24/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task**<br>9-24-15 Remediation Response<br>5. Develop outreach plan based on determined "hot spot" data to schedule & coordinate events for optimal interactions with beneficiaries and navigators. Project leads will measure outcomes of the program as determined by the Clinical Integration and Quality Committee to ensure optimal success by utilizing a continuous process improvement method. Quarterly outcome dashboards will be develop and reported to project teams, CIQC & governance committees to track and adjust program success, if required. Project lead will establish & maintain lines of communication and collaboration with neighboring PPS, leveraging resources to ensure best methodology to engage targeted populations. | Project | | In Progress | 09/24/2015 | 03/31/2017 | 09/24/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #15**<br>Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>Navigators educated about insurance options and healthcare | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| resources available to populations in this project. | | | | | | | | | |
| **Task** 1. Explore streamlining of resource directories into an existing platform(s), such as 2-1-1, to be used by community navigators | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 2. Educate navigators on the use of tools that will contain information on insurance options and healthcare resources | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #16** Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** Timely access for navigator when connecting members to services. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 1. Identify PCP practices in the referring area that are in process of PCMH certification or have achieved NCQA 2014 Level 3 PCMH status and who have open access scheduling availability | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 2. Identify process for connectivity to PCPs and PCMH providers through various avenues, including but not limited to direct conversation, IT solutions and other notification methods | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 3. : Work with PCMH Project Manager from PPS organization structure to maintain current, accurate database for use by navigators, including practice census and appointment availability. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #17** Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 1. Determine requirements for identification of targeted patients and tracking actively engaged patients per state-provided specifications for the DSRIP program. Assess current EHR and | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| other technical platforms in the PPS against these requirements | | | | | | | | | |
| **Task** 2. Create a gap analysis based on the current state analysis to determine incremental IT needs and associated budget, including short-term manual solutions. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 3. Establish a process for monitoring project milestones and performance | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 4. Where electronic functionality is not yet ready, implement alternate in the interim and track conversion to electronic systems | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 5. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Milestone #1** Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate. | | | | | | | | | | |
| **Task** Partnerships with CBOs to assist in patient "hot-spotting" and engagement efforts as evidenced by MOUs, contracts, letters of agreement or other partnership documentation. | | | | | | | | | | |
| **Task** 1. PPS will develop MOUs, contracts and letters of agreement to work in concert to identify and engage uninsured, low utilizers, under-utilizers of healthcare. Identified partners and CBO's will be located utilizing data from the DSRIP Community Needs Assessment and other organizations already working with the targeted population | | | | | | | | | | |
| **Task** 2. PPS will contract with Insignia Healthcare where PAM tool data will be stored for PPS tracking and reporting | | | | | | | | | | |
| **Task** 3. PPS Clinical Operations Team will provide CBOs and partners quarterly reports on PAM tool implementation and statistics | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>4. PPS will create and distribute "hot spot" poster maps to contracted partners and CBO's in this project by utilizing data from our DSRIP Community Needs Assessment and information provided by other community organizations such as HCDI (Healthy Capital District Initiative). PPS will abstract additional information based on the organization's current involvement in serving the population of interest. | | | | | | | | | | |
| **Task**<br>5. The PPS will work in concert with additional regional PPS' (Adirondack Health Institute and Albany Medical Center) where county cross over occurs to collaborate on a coordinated approach to launch Project 11 efforts | | | | | | | | | | |
| **Milestone #2**<br>Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement. | | | | | | | | | | |
| **Task**<br>Patient Activation Measure(R) (PAM(R)) training team established. | | | | | | | | | | |
| **Task**<br>1. PPS will contract with Insignia to provide PAM training on engaging target populations | | | | | | | | | | |
| **Task**<br>2. PPS will elicit volunteers from partners and CBO's to assign PAM "train the trainer" champions | | | | | | | | | | |
| **Task**<br>3. Volunteer Champions will attend coordinated educational planning session with Insignia on July 16, 2015. | | | | | | | | | | |
| **Task**<br>4. Volunteer Champions will continue to attend additional training and webinars provided by Insignia to ensure consistent education on patient activation techniques and documentation requirements | | | | | | | | | | |
| **Task**<br>5. PPS Project 11 Manager will develop and organize additional educational sessions across the PPS utilizing the train the trainer champions and track attendance | | | | | | | | | | |
| **Task**<br>6. PPS Project 11 Manager will track individuals who attend Insignia PAM training and additional training sessions provided by Insignia | | | | | | | | | | |
| **Task**<br>7. PPS Project 11 Manager will collaborate with additional PPS's, CBO's and partners to develop strategy to capture attributed | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| populations that corresponds | | | | | | | | | | |
| **Milestone #3** Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas. | | | | | | | | | | |
| **Task** Analysis to identify "hot spot" areas completed and CBOs performing outreach engaged. | | | | | | | | | | |
| **Task** 1. Create and distribute "hot spot" poster maps developed using data from our DSRIP Community Needs Assessment and other community organizations (HCDI-Healthy Capital District Initiative) based on their current involvement in serving the population of interest. | | | | | | | | | | |
| **Task** 2. Based on the above data, PPS will identify and partner with CBOs that are located in the "hot spot" areas. | | | | | | | | | | |
| **Task** 3. PPS will develop contracts with identified partners and CBOs to perform outreach and engagement efforts | | | | | | | | | | |
| **Task** 4. Collaborate with hospital partners (St. Mary's Healthcare, St. Peter's Health Partners and Ellis Hospital) and partner CBOs (Community Health Center, Living Resources, Schenectady Visiting Nurses) that provide Charity Care to identify additional members for patient activation. | | | | | | | | | | |
| **Task** 5. PPS will arrange for Project 11 retreat to assemble key stakeholders and Workforce Committee to review current hot spot data and determine if there are outlying gaps in the PPS region such as sub-cultures (Amish, Burmese, and Guyanese) that the PPS would need develop additional cultural sensitive plans on how to employ additional community outreach workers to assist in engagement activities. | | | | | | | | | | |
| **Task** 6. Collaborate with Government Officials to acknowledge and decipher legal aspects of health care reform and assistance for illegal immigrants and populations/cultures that are not networked into mainstream society. | | | | | | | | | | |
| **Milestone #4** Survey the targeted population about healthcare needs in the PPS' region. | | | | | | | | | | |
| **Task** Community engagement forums and other information-gathering | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| mechanisms established and performed. | | | | | | | | | | |
| **Task**<br>1. Explore and assess a variety of venues and opportunities to survey the targeted population (e.g. health fairs, community events and forums, shelters, senior centers & church gatherings). | | | | | | | | | | |
| **Task**<br>2. Contract with community assessment experts in developing a survey/questionnaire for participation. Ensure survey is developed based on the DSRIP Community Needs Assessment that is culturally, intellectually and linguistically suitable for participants to complete. | | | | | | | | | | |
| **Task**<br>3. Investigate the potential to contract with professional facilitators to hold community engagement forums to attain first hand attitudes and knowledge regarding one's ability to access and participate in healthcare/self-management | | | | | | | | | | |
| **Milestone #5**<br>Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency. | | | | | | | | | | |
| **Task**<br>PPS Providers (located in "hot spot" areas) trained in patient activation techniques by "PAM(R) trainers". | | | | | | | | | | |
| **Task**<br>1. Project Manager and Workforce Committee will develop educational tracking mechanisms to track all providers who receive training for reporting | | | | | | | | | | |
| **Task**<br>2. The PPS Cultural Competency Taskforce will collaborate with Iroquois Healthcare Alliance to develop curriculum and training programs that will address patient activation techniques. | | | | | | | | | | |
| **Task**<br>3. The PPS will offer a variety of venues (webinars, in-person, online) courses to enhance the availability of providers to receive training. Continue to utilize volunteer PAM train the trainers to provide onsite training at provider sites. | | | | | | | | | | |
| **Milestone #6**<br>Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10).<br>• This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| connectivity to resources already available to the member.<br>• Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104. | | | | | | | | | | |
| **Task**<br>Procedures and protocols established to allow the PPS to work with the member's MCO and assigned PCP to help reconnect that beneficiary to his/her designated PCP. | | | | | | | | | | |
| **Task**<br>1. Engage with the 3 Lead Health Homes in the PPS (St. Mary's Healthcare, Care Central-Ellis & Samaritan) to determine if DEAA/BAA feasibility for the review of Health Home Assignment files that denotes an attributed member with their last 5 healthcare encounters. This would allow community outreach workers to reconnect members to their PCP, administer PAM activations tool and assist members with referrals to Health Home Care Management services and other entitlement needs | | | | | | | | | | |
| **Task**<br>2. Evaluate how each MCO determines PCP selection or assignment for their members | | | | | | | | | | |
| **Task**<br>3. Coordinate & contract with the three leading Health Homes and downstream care coordination agencies, within our PPS, to assist with proactive outreach activities and administration of the PAM assessment tool. | | | | | | | | | | |
| **Task**<br>4. The PPS in concert with the MCO and partnering PCPs, will develop systematic protocol for access and read only rights to assess those designated as NU and LU of healthcare services to appropriate redirect care back to the designated/chosen provider of choice. | | | | | | | | | | |
| **Milestone #7**<br>Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period. | | | | | | | | | | |
| **Task**<br>For each PAM(R) activation level, baseline and set intervals toward improvement determined at the beginning of each performance period (defined by the state). | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>1. Coordinate with the state on obtaining the method for establishing a baseline for each beneficiary based on network assessment | | | | | | | | | | |
| **Task**<br>2. Leverage data gained from PAM tool and working with PCP's to establish baselines and intervals toward improvement for each performance period. | | | | | | | | | | |
| **Task**<br>3. Develop plans to validate patient population and identify method to improvement engagement | | | | | | | | | | |
| **Milestone #8**<br>Include beneficiaries in development team to promote preventive care. | | | | | | | | | | |
| **Task**<br>Beneficiaries are utilized as a resource in program development and awareness efforts of preventive care services. | | | | | | | | | | |
| **Task**<br>1. Investigate the potential to contract with professional facilitators to hold community engagement forums. This will allow the PPS to collectively gain personal insight, beliefs and bias that beneficiaries may have that prevents them from accessing needed healthcare | | | | | | | | | | |
| **Task**<br>2. Collaborate with Cultural Broker Program developed through the Cultural Competency Taskforce | | | | | | | | | | |
| **Task**<br>3. Utilize the AHRQ Working With Patient and Families as Advisers Implementation Handbook as a guide to develop a training program for adviser roles in the PPS | | | | | | | | | | |
| **Milestone #9**<br>Measure PAM(R) components, including:<br>• Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service.<br>• If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM(R) survey and designate a PAM(R) score.<br>• Individual member's score must be averaged to calculate a baseline measure for that year's cohort.<br>• The cohort must be followed for the entirety of the DSRIP program.<br>• On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| beneficiaries to a higher level of activation. • If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP.<br>• The PPS will NOT be responsible for assessing the patient via PAM(R) survey.<br>• PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes.<br>• Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis. | | | | | | | | | | |
| **Task**<br>Performance measurement reports established, including but not limited to:<br>- Number of patients screened, by engagement level<br>- Number of clinicians trained in PAM(R) survey implementation<br>- Number of patient: PCP bridges established<br>- Number of patients identified, linked by MCOs to which they are associated<br>- Member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis<br>- Member engagement lists to DOH (for NU & LU populations) on a monthly basis<br>- Annual report assessing individual member and the overall cohort's level of engagement | | | | | | | | | | |
| **Task**<br>1. Utilize information from the PAM admin tool to collect required information and training logs to report against required metrics. | | | | | | | | | | |
| **Task**<br>2. Establish protocols and procedures for the community navigators to screen, assess, and administer the PAM® tool with eligible populations. | | | | | | | | | | |
| **Task**<br>3. Project 11 Team will develop pathways for community navigators to utilize when additional support is needed to assist the member through the various stages of the PAM assessment determination | | | | | | | | | | |
| **Task**<br>4. Collaborate with Insignia to create and deliver reporting data. Provide feedback to PCPs and MCOs regarding level of engagement, reassessment and overall participation statistics | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>5. Identify process for connectivity to PCPs and PCMH providers through various avenues, including but not limited to direct conversation, IT solutions and other notification methods. | | | | | | | | | | |
| **Task**<br>6. Develop tool to be used by community navigators to assess cultural, linguistic and other needs that will enable placement with the most appropriate provider. | | | | | | | | | | |
| **Milestone #10**<br>Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons. | | | | | | | | | | |
| **Task**<br>Volume of non-emergent visits for UI, NU, and LU populations increased. | | | | | | | | | | |
| **Task**<br>1. The PPS Project Manager will work in conjunction with 2 b iii Project Lead to conduct a gap analysis and ongoing assessment of our PCMH partners to determine capacity and service specialty. | | | | | | | | | | |
| **Task**<br>2. Utilize the PPS website and provide a 'quick link' for community outreach workers to obtain current PCMH capacity and service information (ie: hours operation, accepting of new pts, etc) | | | | | | | | | | |
| **Task**<br>3. Identify providers with open scheduling and capacity to accept returning patients, new patients or who need specialized service such as dentistry. | | | | | | | | | | |
| **Task**<br>4. Develop a referral process for community navigators to assess needs and link members to additional service providers. | | | | | | | | | | |
| **Milestone #11**<br>Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education. | | | | | | | | | | |
| **Task**<br>Community navigators identified and contracted. | 0 | 0 | 0 | 36 | 84 | 144 | 216 | 300 | 300 | 300 |
| **Task**<br>Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including primary and preventive services), as well as patient education. | 0 | 0 | 0 | 36 | 84 | 144 | 216 | 300 | 300 | 300 |
| **Task**<br>1. Collaborate with AFBHC leadership and CBOs who provide navigation services to develop contracts for outreach and | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| engagement activities. | | | | | | | | | | |
| **Task**<br>2. Engage Workforce Committee to perform a gap analysis to determine workforce resources and training needs. | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>3. Working with our community partners to develop strategies to identify or engage potential navigators who represent the populations served. | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation response<br>4. Develop a broad approach to train navigators to administer the PAM tool. | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>5. Identify the appropriate number and locations of navigators needed to utilize the PAM tool to meet the engagement commitments. Evaluate effectiveness of approach and address opportunities for improvement for work performed by the patient navigators. | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>6. Develop a training strategy for established navigators that incorporates a periodic review of PAM administration techniques. Offer opportunities to leverage the experience of the successful navigators to partner with lower performing navigators.(i.e.: the rate of patients who decline opportunity to complete the PAM once the process is initiated). | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>7. Based on CNA and workforce analysis, develop a methodology for piloting the PAM tool rollout, placement of trained navigators and expectations of engagement numbers a targeted locations. | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>8. Develop process to identify areas for roll out of PAM tool and placement of trained navigators. | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>9. Once the pilot rollout is achieved and redefined, if needed for improved outcomes, contrinue to roll out PAM engagements sessions to achieve desired quotient of patient engagment. | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>9-24-15 Remediation Response<br>10. Evaluate success of the program using workforce feedback, aggregation of engagment data and process improvements based on outcomes. | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>11. Develop quarterly outcome dashboards and report to project teams, Clinical Integration and Quality Committee and Goverance committees to track and adjust program success when required. | | | | | | | | | | |
| **Milestone #12**<br>Develop a process for Medicaid recipients and project participants to report complaints and receive customer service. | | | | | | | | | | |
| **Task**<br>Policies and procedures for customer service complaints and appeals developed. | | | | | | | | | | |
| **Task**<br>1. The Alliance for Better Health Care has established an anonymous compliance hotline. Anyone may call the hotline or enter a concern on the web. The hotline is managed by an independent third party, Navex Global. Once a concern is received by the third party, a report is immediately sent to the Alliance's compliance officer. The compliance officer follows up on all concerns. A log is maintained of all concerns and the respective follow up actions. Hotline calls will be shared with the Audit and Compliance Committee quarterly. | | | | | | | | | | |
| **Task**<br>2. Calls made directly to the Corporate Compliance Officer will establish an internal investigation and respond in an agreed-upon manner with the member. | | | | | | | | | | |
| **Task**<br>9-24-15: Remediation Response<br>3. Policy and procedures for customer service complaints and appeals will be established & will, at a minimum, address the following key components:<br>a. Members will have the availability to call the PPS, leave any questions/concerns/complaints regarding the NYS DOH DSRIP program on the 24 hour hotline or may submit a written complaint to the Corporate Compliance Officer for the Alliance for Better Health Care to 14 Columbia Circle , Albany NY 12203.<br>Themes for complaint resolution would include: Resolve issues where all information is available within the first call, if health is at risk within 48 hours of all information being available, otherwise within 7 days and not longer than 60. | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>9-24-15 Remediation Response:<br>The compliance committee will track, aggregate & report complaints & resolutions & outcomes to the Project lead (s) and Clinical Integration and Quality Committee to ensure optimal awareness and quality improvement. Quarterly outcome dashboards will be developed & reported to project teams, CQIC & governance committees to track & adjust program success, if required. | | | | | | | | | | |
| **Milestone #13**<br>Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R). | | | | | | | | | | |
| **Task**<br>List of community navigators formally trained in the PAM(R). | 0 | 0 | 0 | 36 | 84 | 144 | 216 | 300 | 300 | 300 |
| **Task**<br>1. Community navigators embedded in "hot spots" will receive PAM® training through the PPS-wide training team (see requirement #2) | | | | | | | | | | |
| **Task**<br>2. Mechanism for tracking training of community navigators will be developed with our IT consultants | | | | | | | | | | |
| **Milestone #14**<br>Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources. | | | | | | | | | | |
| **Task**<br>Community navigators prominently placed (with high visibility) at appropriate locations within identified "hot spot" areas. | 0 | 0 | 0 | 36 | 84 | 144 | 216 | 300 | 300 | 300 |
| **Task**<br>1. Based on the "hot spot" data, AFBHC will identify and partner with CBOs and ensure a presence at community events in these areas | | | | | | | | | | |
| **Task**<br>2. Assess feasibility of co-locating community navigators at established Navigator Agency sites that provide facilitated insurance enrollment | | | | | | | | | | |
| **Task**<br>3. Create a directory (map) of sites where community navigators are located across the 6-county region | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>4. Develop a PPS-level strategy to screen person status (UI, | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| NU, & LU) & collect contact information when they visit the PPS designated facility or "hot spot" area for health services or other social services. | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>5. Develop outreach plan based on determined "hot spot" data to schedule & coordinate events for optimal interactions with beneficiaries and navigators. Project leads will measure outcomes of the program as determined by the Clinical Integration and Quality Committee to ensure optimal success by utilizing a continuous process improvement method. Quarterly outcome dashboards will be develop and reported to project teams, CIQC & governance committees to track and adjust program success, if required. Project lead will establish & maintain lines of communication and collaboration with neighboring PPS, leveraging resources to ensure best methodology to engage targeted populations. | | | | | | | | | | |
| **Milestone #15**<br>Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations. | | | | | | | | | | |
| **Task**<br>Navigators educated about insurance options and healthcare resources available to populations in this project. | | | | | | | | | | |
| **Task**<br>1. Explore streamlining of resource directories into an existing platform(s), such as 2-1-1, to be used by community navigators | | | | | | | | | | |
| **Task**<br>2. Educate navigators on the use of tools that will contain information on insurance options and healthcare resources | | | | | | | | | | |
| **Milestone #16**<br>Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member. | | | | | | | | | | |
| **Task**<br>Timely access for navigator when connecting members to services. | | | | | | | | | | |
| **Task**<br>1. Identify PCP practices in the referring area that are in process of PCMH certification or have achieved NCQA 2014 Level 3 PCMH status and who have open access scheduling availability | | | | | | | | | | |
| **Task**<br>2. Identify process for connectivity to PCPs and PCMH providers through various avenues, including but not limited to direct conversation, IT solutions and other notification methods | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>3. : Work with PCMH Project Manager from PPS organization structure to maintain current, accurate database for use by navigators, including practice census and appointment availability. | | | | | | | | | | |
| **Milestone #17**<br>Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project. | | | | | | | | | | |
| **Task**<br>PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting. | | | | | | | | | | |
| **Task**<br>1. Determine requirements for identification of targeted patients and tracking actively engaged patients per state-provided specifications for the DSRIP program. Assess current EHR and other technical platforms in the PPS against these requirements | | | | | | | | | | |
| **Task**<br>2. Create a gap analysis based on the current state analysis to determine incremental IT needs and associated budget, including short-term manual solutions. | | | | | | | | | | |
| **Task**<br>3. Establish a process for monitoring project milestones and performance | | | | | | | | | | |
| **Task**<br>4. Where electronic functionality is not yet ready, implement alternate in the interim and track conversion to electronic systems | | | | | | | | | | |
| **Task**<br>5. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS. | | | | | | | | | | |

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Milestone #1**<br>Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate. | | | | | | | | | | |
| **Task**<br>Partnerships with CBOs to assist in patient "hot-spotting" and engagement efforts as evidenced by MOUs, contracts, letters of agreement or other partnership documentation. | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>1. PPS will develop MOUs, contracts and letters of agreement to work in concert to identify and engage uninsured, low utilizers, under-utilizers of healthcare. Identified partners and CBO's will be located utilizing data from the DSRIP Community Needs Assessment and other organizations already working with the targeted population | | | | | | | | | | |
| **Task**<br>2. PPS will contract with Insignia Healthcare where PAM tool data will be stored for PPS tracking and reporting | | | | | | | | | | |
| **Task**<br>3. PPS Clinical Operations Team will provide CBOs and partners quarterly reports on PAM tool implementation and statistics | | | | | | | | | | |
| **Task**<br>4. PPS will create and distribute "hot spot" poster maps to contracted partners and CBO's in this project by utilizing data from our DSRIP Community Needs Assessment and information provided by other community organizations such as HCDI (Healthy Capital District Initiative). PPS will abstract additional information based on the organization's current involvement in serving the population of interest. | | | | | | | | | | |
| **Task**<br>5. The PPS will work in concert with additional regional PPS' (Adirondack Health Institute and Albany Medical Center) where county cross over occurs to collaborate on a coordinated approach to launch Project 11 efforts | | | | | | | | | | |
| **Milestone #2**<br>Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement. | | | | | | | | | | |
| **Task**<br>Patient Activation Measure(R) (PAM(R)) training team established. | | | | | | | | | | |
| **Task**<br>1. PPS will contract with Insignia to provide PAM training on engaging target populations | | | | | | | | | | |
| **Task**<br>2. PPS will elicit volunteers from partners and CBO's to assign PAM "train the trainer" champions | | | | | | | | | | |
| **Task**<br>3. Volunteer Champions will attend coordinated educational planning session with Insignia on July 16, 2015. | | | | | | | | | | |
| **Task**<br>4. Volunteer Champions will continue to attend additional training and webinars provided by Insignia to ensure consistent | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| education on patient activation techniques and documentation requirements | | | | | | | | | | |
| **Task**<br>5. PPS Project 11 Manager will develop and organize additional educational sessions across the PPS utilizing the train the trainer champions and track attendance | | | | | | | | | | |
| **Task**<br>6. PPS Project 11 Manager will track individuals who attend Insignia PAM training and additional training sessions provided by Insignia | | | | | | | | | | |
| **Task**<br>7. PPS Project 11 Manager will collaborate with additional PPS's, CBO's and partners to develop strategy to capture attributed populations that corresponds | | | | | | | | | | |
| **Milestone #3**<br>Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas. | | | | | | | | | | |
| **Task**<br>Analysis to identify "hot spot" areas completed and CBOs performing outreach engaged. | | | | | | | | | | |
| **Task**<br>1. Create and distribute "hot spot" poster maps developed using data from our DSRIP Community Needs Assessment and other community organizations (HCDI-Healthy Capital District Initiative) based on their current involvement in serving the population of interest. | | | | | | | | | | |
| **Task**<br>2. Based on the above data, PPS will identify and partner with CBOs that are located in the "hot spot" areas. | | | | | | | | | | |
| **Task**<br>3. PPS will develop contracts with identified partners and CBOs to perform outreach and engagement efforts | | | | | | | | | | |
| **Task**<br>4. Collaborate with hospital partners (St. Mary's Healthcare, St. Peter's Health Partners and Ellis Hospital) and partner CBOs (Community Health Center, Living Resources, Schenectady Visiting Nurses) that provide Charity Care to identify additional members for patient activation. | | | | | | | | | | |
| **Task**<br>5. PPS will arrange for Project 11 retreat to assemble key stakeholders and Workforce Committee to review current hot spot data and determine if there are outlying gaps in the PPS region such as sub-cultures (Amish, Burmese, and Guyanese) that the PPS would need develop additional cultural sensitive | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| plans on how to employ additional community outreach workers to assist in engagement activities. | | | | | | | | | | |
| **Task**<br>6. Collaborate with Government Officials to acknowledge and decipher legal aspects of health care reform and assistance for illegal immigrants and populations/cultures that are not networked into mainstream society. | | | | | | | | | | |
| **Milestone #4**<br>Survey the targeted population about healthcare needs in the PPS' region. | | | | | | | | | | |
| **Task**<br>Community engagement forums and other information-gathering mechanisms established and performed. | | | | | | | | | | |
| **Task**<br>1. Explore and assess a variety of venues and opportunities to survey the targeted population (e.g. health fairs, community events and forums, shelters, senior centers & church gatherings). | | | | | | | | | | |
| **Task**<br>2. Contract with community assessment experts in developing a survey/questionnaire for participation. Ensure survey is developed based on the DSRIP Community Needs Assessment that is culturally, intellectually and linguistically suitable for participants to complete. | | | | | | | | | | |
| **Task**<br>3. Investigate the potential to contract with professional facilitators to hold community engagement forums to attain first hand attitudes and knowledge regarding one's ability to access and participate in healthcare/self-management | | | | | | | | | | |
| **Milestone #5**<br>Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency. | | | | | | | | | | |
| **Task**<br>PPS Providers (located in "hot spot" areas) trained in patient activation techniques by "PAM(R) trainers". | | | | | | | | | | |
| **Task**<br>1. Project Manager and Workforce Committee will develop educational tracking mechanisms to track all providers who receive training for reporting | | | | | | | | | | |
| **Task**<br>2. The PPS Cultural Competency Taskforce will collaborate with Iroquois Healthcare Alliance to develop curriculum and training programs that will address patient activation techniques. | | | | | | | | | | |
| **Task**<br>3. The PPS will offer a variety of venues (webinars, in-person, | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| online) courses to enhance the availability of providers to receive training. Continue to utilize volunteer PAM train the trainers to provide onsite training at provider sites. | | | | | | | | | | |
| **Milestone #6**<br>Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10).<br>• This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member.<br>• Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104. | | | | | | | | | | |
| **Task**<br>Procedures and protocols established to allow the PPS to work with the member's MCO and assigned PCP to help reconnect that beneficiary to his/her designated PCP. | | | | | | | | | | |
| **Task**<br>1. Engage with the 3 Lead Health Homes in the PPS (St. Mary's Healthcare, Care Central-Ellis & Samaritan) to determine if DEAA/BAA feasibility for the review of Health Home Assignment files that denotes an attributed member with their last 5 healthcare encounters. This would allow community outreach workers to reconnect members to their PCP, administer PAM activations tool and assist members with referrals to Health Home Care Management services and other entitlement needs | | | | | | | | | | |
| **Task**<br>2. Evaluate how each MCO determines PCP selection or assignment for their members | | | | | | | | | | |
| **Task**<br>3. Coordinate & contract with the three leading Health Homes and downstream care coordination agencies, within our PPS, to assist with proactive outreach activities and administration of the PAM assessment tool. | | | | | | | | | | |
| **Task**<br>4. The PPS in concert with the MCO and partnering PCPs, will develop systematic protocol for access and read only rights to assess those designated as NU and LU of healthcare services to | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| appropriate redirect care back to the designated/chosen provider of choice. | | | | | | | | | | |
| **Milestone #7** Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period. | | | | | | | | | | |
| **Task** For each PAM(R) activation level, baseline and set intervals toward improvement determined at the beginning of each performance period (defined by the state). | | | | | | | | | | |
| **Task** 1. Coordinate with the state on obtaining the method for establishing a baseline for each beneficiary based on network assessment | | | | | | | | | | |
| **Task** 2. Leverage data gained from PAM tool and working with PCP's to establish baselines and intervals toward improvement for each performance period. | | | | | | | | | | |
| **Task** 3. Develop plans to validate patient population and identify method to improvement engagement | | | | | | | | | | |
| **Milestone #8** Include beneficiaries in development team to promote preventive care. | | | | | | | | | | |
| **Task** Beneficiaries are utilized as a resource in program development and awareness efforts of preventive care services. | | | | | | | | | | |
| **Task** 1. Investigate the potential to contract with professional facilitators to hold community engagement forums. This will allow the PPS to collectively gain personal insight, beliefs and bias that beneficiaries may have that prevents them from accessing needed healthcare | | | | | | | | | | |
| **Task** 2. Collaborate with Cultural Broker Program developed through the Cultural Competency Taskforce | | | | | | | | | | |
| **Task** 3. Utilize the AHRQ Working With Patient and Families as Advisers Implementation Handbook as a guide to develop a training program for adviser roles in the PPS | | | | | | | | | | |
| **Milestone #9** Measure PAM(R) components, including: | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| • Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service.<br>• If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM(R) survey and designate a PAM(R) score.<br>• Individual member's score must be averaged to calculate a baseline measure for that year's cohort.<br>• The cohort must be followed for the entirety of the DSRIP program.<br>• On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation. • If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP.<br>• The PPS will NOT be responsible for assessing the patient via PAM(R) survey.<br>• PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes.<br>• Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis. | | | | | | | | | | |
| **Task**<br>Performance measurement reports established, including but not limited to:<br>- Number of patients screened, by engagement level<br>- Number of clinicians trained in PAM(R) survey implementation<br>- Number of patient: PCP bridges established<br>- Number of patients identified, linked by MCOs to which they are associated<br>- Member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis<br>- Member engagement lists to DOH (for NU & LU populations) on a monthly basis<br>- Annual report assessing individual member and the overall cohort's level of engagement | | | | | | | | | | |
| **Task**<br>1. Utilize information from the PAM admin tool to collect required information and training logs to report against required metrics. | | | | | | | | | | |
| **Task** | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| 2. Establish protocols and procedures for the community navigators to screen, assess, and administer the PAM® tool with eligible populations. | | | | | | | | | | |
| **Task**<br>3. Project 11 Team will develop pathways for community navigators to utilize when additional support is needed to assist the member through the various stages of the PAM assessment determination | | | | | | | | | | |
| **Task**<br>4. Collaborate with Insignia to create and deliver reporting data. Provide feedback to PCPs and MCOs regarding level of engagement, reassessment and overall participation statistics | | | | | | | | | | |
| **Task**<br>5. Identify process for connectivity to PCPs and PCMH providers through various avenues, including but not limited to direct conversation, IT solutions and other notification methods. | | | | | | | | | | |
| **Task**<br>6. Develop tool to be used by community navigators to assess cultural, linguistic and other needs that will enable placement with the most appropriate provider. | | | | | | | | | | |
| **Milestone #10**<br>Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons. | | | | | | | | | | |
| **Task**<br>Volume of non-emergent visits for UI, NU, and LU populations increased. | | | | | | | | | | |
| **Task**<br>1. The PPS Project Manager will work in conjunction with 2 b iii Project Lead to conduct a gap analysis and ongoing assessment of our PCMH partners to determine capacity and service specialty. | | | | | | | | | | |
| **Task**<br>2. Utilize the PPS website and provide a 'quick link' for community outreach workers to obtain current PCMH capacity and service information (ie: hours operation, accepting of new pts, etc) | | | | | | | | | | |
| **Task**<br>3. Identify providers with open scheduling and capacity to accept returning patients, new patients or who need specialized service such as dentistry. | | | | | | | | | | |
| **Task**<br>4. Develop a referral process for community navigators to assess needs and link members to additional service providers. | | | | | | | | | | |
| **Milestone #11**<br>Contract or partner with CBOs to develop a group of community | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education. | | | | | | | | | | |
| **Task**<br>Community navigators identified and contracted. | 300 | 300 | 300 | 300 | 300 | 300 | 300 | 300 | 300 | 300 |
| **Task**<br>Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including primary and preventive services), as well as patient education. | 300 | 300 | 300 | 300 | 300 | 300 | 300 | 300 | 300 | 300 |
| **Task**<br>1. Collaborate with AFBHC leadership and CBOs who provide navigation services to develop contracts for outreach and engagement activities. | | | | | | | | | | |
| **Task**<br>2. Engage Workforce Committee to perform a gap analysis to determine workforce resources and training needs. | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>3. Working with our community partners to develop strategies to identify or engage potential navigators who represent the populations served. | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation response<br>4. Develop a broad approach to train navigators to administer the PAM tool. | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>5. Identify the appropriate number and locations of navigators needed to utilize the PAM tool to meet the engagement commitments. Evaluate effectiveness of approach and address opportunities for improvement for work performed by the patient navigators. | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>6. Develop a training strategy for established navigators that incorporates a periodic review of PAM administration techniques. Offer opportunities to leverage the experience of the successful navigators to partner with lower performing navigators.(i.e.: the rate of patients who decline opportunity to complete the PAM once the process is initiated). | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>7. Based on CNA and workforce analysis, develop a methodology for piloting the PAM tool rollout, placement of trained navigators and expectations of engagement numbers a | | | | | | | | | | |

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| targeted locations. | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>8. Develop process to identify areas for roll out of PAM tool and placement of trained navigators. | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>9. Once the pilot rollout is achieved and redefined, if needed for improved outcomes, contrinue to roll out PAM engagements sessions to achieve desired quotient of patient engagment. | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>10. Evaluate success of the program using workforce feedback, aggregation of engagment data and process improvements based on outcomes. | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>11. Develop quarterly outcome dashboards and report to project teams, Clinical Integration and Quality Committee and Goverance committees to track and adjust program success when required. | | | | | | | | | | |
| **Milestone #12**<br>Develop a process for Medicaid recipients and project participants to report complaints and receive customer service. | | | | | | | | | | |
| **Task**<br>Policies and procedures for customer service complaints and appeals developed. | | | | | | | | | | |
| **Task**<br>1. The Alliance for Better Health Care has established an anonymous compliance hotline. Anyone may call the hotline or enter a concern on the web. The hotline is managed by an independent third party, Navex Global. Once a concern is received by the third party, a report is immediately sent to the Alliance's compliance officer. The compliance officer follows up on all concerns. A log is maintained of all concerns and the respective follow up actions. Hotline calls will be shared with the Audit and Compliance Committee quarterly. | | | | | | | | | | |
| **Task**<br>2. Calls made directly to the Corporate Compliance Officer will establish an internal investigation and respond in an agreed-upon manner with the member. | | | | | | | | | | |
| **Task**<br>9-24-15: Remediation Response<br>3. Policy and procedures for customer service complaints and | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| appeals will be established & will, at a minimum, address the following key components:<br>a. Members will have the availability to call the PPS, leave any questions/concerns/complaints regarding the NYS DOH DSRIP program on the 24 hour hotline or may submit a written complaint to the Corporate Compliance Officer for the Alliance for Better Health Care to 14 Columbia Circle , Albany NY 12203.<br>Themes for complaint resolution would include: Resolve issues where all information is available within the first call, if health is at risk within 48 hours of all information being available, otherwise within 7 days and not longer than 60. | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response:<br>The compliance committee will track, aggregate & report complaints & resolutions & outcomes to the Project lead (s) and Clinical Integration and Quality Committee to ensure optimal awareness and quality improvement. Quarterly outcome dashboards will be developed & reported to project teams, CQIC & governance committees to track & adjust program success, if required. | | | | | | | | | | |
| **Milestone #13**<br>Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R). | | | | | | | | | | |
| **Task**<br>List of community navigators formally trained in the PAM(R). | 300 | 300 | 300 | 300 | 300 | 300 | 300 | 300 | 300 | 300 |
| **Task**<br>1. Community navigators embedded in "hot spots" will receive PAM® training through the PPS-wide training team (see requirement #2) | | | | | | | | | | |
| **Task**<br>2. Mechanism for tracking training of community navigators will be developed with our IT consultants | | | | | | | | | | |
| **Milestone #14**<br>Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources. | | | | | | | | | | |
| **Task**<br>Community navigators prominently placed (with high visibility) at appropriate locations within identified "hot spot" areas. | 300 | 300 | 300 | 300 | 300 | 300 | 300 | 300 | 300 | 300 |
| **Task**<br>1. Based on the "hot spot" data, AFBHC will identify and partner with CBOs and ensure a presence at community events in these | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| areas | | | | | | | | | | |
| **Task**<br>2. Assess feasibility of co-locating community navigators at established Navigator Agency sites that provide facilitated insurance enrollment | | | | | | | | | | |
| **Task**<br>3. Create a directory (map) of sites where community navigators are located across the 6-county region | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>4. Develop a PPS-level strategy to screen person status (UI, NU, & LU) & collect contact information when they visit the PPS designated facility or "hot spot" area for health services or other social services. | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>5. Develop outreach plan based on determined "hot spot" data to schedule & coordinate events for optimal interactions with beneficiaries and navigators. Project leads will measure outcomes of the program as determined by the Clinical Integration and Quality Committee to ensure optimal success by utilizing a continuous process improvement method. Quarterly outcome dashboards will be develop and reported to project teams, CIQC & governance committees to track and adjust program success, if required. Project lead will establish & maintain lines of communication and collaboration with neighboring PPS, leveraging resources to ensure best methodology to engage targeted populations. | | | | | | | | | | |
| **Milestone #15**<br>Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations. | | | | | | | | | | |
| **Task**<br>Navigators educated about insurance options and healthcare resources available to populations in this project. | | | | | | | | | | |
| **Task**<br>1. Explore streamlining of resource directories into an existing platform(s), such as 2-1-1, to be used by community navigators | | | | | | | | | | |
| **Task**<br>2. Educate navigators on the use of tools that will contain information on insurance options and healthcare resources | | | | | | | | | | |
| **Milestone #16**<br>Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member. | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>Timely access for navigator when connecting members to services. | | | | | | | | | | |
| **Task**<br>1. Identify PCP practices in the referring area that are in process of PCMH certification or have achieved NCQA 2014 Level 3 PCMH status and who have open access scheduling availability | | | | | | | | | | |
| **Task**<br>2. Identify process for connectivity to PCPs and PCMH providers through various avenues, including but not limited to direct conversation, IT solutions and other notification methods | | | | | | | | | | |
| **Task**<br>3. : Work with PCMH Project Manager from PPS organization structure to maintain current, accurate database for use by navigators, including practice census and appointment availability. | | | | | | | | | | |
| **Milestone #17**<br>Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project. | | | | | | | | | | |
| **Task**<br>PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting. | | | | | | | | | | |
| **Task**<br>1. Determine requirements for identification of targeted patients and tracking actively engaged patients per state-provided specifications for the DSRIP program. Assess current EHR and other technical platforms in the PPS against these requirements | | | | | | | | | | |
| **Task**<br>2. Create a gap analysis based on the current state analysis to determine incremental IT needs and associated budget, including short-term manual solutions. | | | | | | | | | | |
| **Task**<br>3. Establish a process for monitoring project milestones and performance | | | | | | | | | | |
| **Task**<br>4. Where electronic functionality is not yet ready, implement alternate in the interim and track conversion to electronic systems | | | | | | | | | | |
| **Task**<br>5. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS. | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Prescribed Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|

No Records Found

### Prescribed Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|
| Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate. | |
| Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement. | |
| Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas. | |
| Survey the targeted population about healthcare needs in the PPS' region. | |
| Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency. | |
| Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10).<br>• This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member.<br>• Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104. | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Prescribed Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|
| Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period. | |
| Include beneficiaries in development team to promote preventive care. | |
| Measure PAM(R) components, including:<br>• Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service.<br>• If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM(R) survey and designate a PAM(R) score.<br>• Individual member's score must be averaged to calculate a baseline measure for that year's cohort.<br>• The cohort must be followed for the entirety of the DSRIP program.<br>• On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation. • If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP.<br>• The PPS will NOT be responsible for assessing the patient via PAM(R) survey.<br>• PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes.<br>• Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis. | |
| Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons. | |
| Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Prescribed Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|
| community healthcare resources (including for primary and preventive services) and patient education. | |
| Develop a process for Medicaid recipients and project participants to report complaints and receive customer service. | |
| Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R). | |
| Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources. | |
| Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations. | |
| Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member. | |
| Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project. | |

### Milestone Review Status

| Milestone # | Review Status | IA Formal Comments |
|---|---|---|
| **Milestone #1** | Pass & Ongoing | |
| **Milestone #2** | Pass & Ongoing | |
| **Milestone #3** | Pass & Ongoing | |
| **Milestone #4** | Pass & Ongoing | |
| **Milestone #5** | Pass & Ongoing | |
| **Milestone #6** | Pass & Ongoing | |
| **Milestone #7** | Pass & Ongoing | |
| **Milestone #8** | Pass & Ongoing | |
| **Milestone #9** | Pass & Ongoing | |

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# Delivery System Reform Incentive Payment Project

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Milestone Review Status

| Milestone # | Review Status | IA Formal Comments |
|---|---|---|
| **Milestone #10** | Pass & Ongoing | |
| **Milestone #11** | Pass & Ongoing | |
| **Milestone #12** | Pass & Ongoing | |
| **Milestone #13** | Pass & Ongoing | |
| **Milestone #14** | Pass & Ongoing | |
| **Milestone #15** | Pass & Ongoing | |
| **Milestone #16** | Pass & Ongoing | |
| **Milestone #17** | Pass & Ongoing | |

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### IPQR Module 2.d.i.4 - PPS Defined Milestones

**Instructions :**

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for PPS-defined milestones.

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|

No Records Found

# New York State Department Of Health
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## Alliance for Better Health Care, LLC  (PPS ID:3)

### IPQR Module 2.d.i.5 - IA Monitoring

**Instructions :**

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## Alliance for Better Health Care, LLC (PPS ID:3)

### Project 3.a.i – Integration of primary care and behavioral health services

#### IPQR Module 3.a.i.1 - Major Risks to Implementation and Mitigation Strategies

**Instructions :**

Please describe what the major risks are for this project, as well as the actions you plan to take to mitigate them.

Two regulations run counter to the project objectives of co-locating PC and BH services and are risks to the success of the project. The existing threshold billing regulations prohibit billing for Primary Care and Behavioral Health Services on the same day and the locations of Article 31 clinics are stringently defined. The PPS mitigation strategy has been to advocate for regulatory relief, apply for waivers permitted with the DSRIP initiative, explore alternative payment methodologies, and seek alternate ways to reduce the physical distance between providers. Successful mitigation will be seen in the regulatory waivers being granted.

Provider perceptions about patients with behavioral health and substance use disorders can negatively impact primary care provider engagement and, in turn, are risks to the success of this project. The PPS's mitigation strategy includes: providing age appropriate cultural competency and health literacy training to primary care practice sites and tracking completion of trainings; identifying and resolving physical barriers (i.e. entrances, waiting rooms, etc.) and stigma at practice sites that reduce provider participation; and, supporting care management according to patient need to address patient barriers to behavioral and medical care. Success of the mitigation strategy will be seen in the number of providers accepting patients with behavioral health and substance use disorders.

Another risk to the successful completion of this project is that the PPS does not achieve NCQA recognition for its primary care practices by DY3, Q4. To mitigate this risk, the PPS is identifying at least one project manager to PCMH certification. Current state of the practices will be assessed, technical assistance needs identified and technical assistance provided from the PPS central project management office. Success of the mitigation strategy is that all providers achieve NCQA recognition within the targeted timeframe.

There are multiple IT Risks, such as data interoperability dependent upon working with multiple vendors that may not support existing standards- the risk mitigation strategy is to engage vendors early & determine supplemental solutions where available. The RHIO, which is expected to be the interoperable clinical platform, has expressed limitations on data sharing per NY state policies, working with EHR vendors to achieve data sharing & balancing the needs of DSRIP with their existing commitments. As Population Health IT (PHIT) systems and tools are required, any delay to PHIT implementation delays the projects & risks not meeting speed & scale requirements. PHIT rollout depends on sufficient capital funding from NY state & delay in the capital release will delay the rollout. The PPS will work closely with the RHIO, accelerate implementation of PHIT interoperability & tools, use alternate methods where EHRs & PHIT tool functionality aren't yet ready & work with NY to ensure capital is provided in sufficient time.

As health care transitions to the outpatient setting, the PPS risks overwhelming providers with expectations associated with the DSRIP projects. The mitigation strategy is to bundle interventions as much as possible; to demonstrate the common links between DSRIP requirements, and to provide technical support, tools, training and measuring awareness will surveys to practices from the PPS administrative offices. Success of the mitigation strategy will be seen with project requirements being met within the targeted timeframes.

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### IPQR Module 3.a.i.2 - Patient Engagement Speed

**Instructions :**

Enter the number of patients actively engaged through the current quarter. The number entered into the "Patient Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for DY1 Q3 should include patients previously reported in DY1 Q2 plus new patients engaged in DY1 Q3. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

| Benchmarks | |
|---|---|
| **100% Actively Engaged By** | **Expected Patient Engagement** |
| DY4,Q4 | 57,533 |

| Patients Engaged to Date in Current DY | DY1,Q3 Patient Update | % of Semi-Annual Commitment To-Date | Semi-Annual Variance of Projected to Actual | % of Total Actively Engaged Patients To-Date |
|---|---|---|---|---|
| 1,086 | 1,086 | 16.31% | 5,573 | 1.89% |

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (6,659)

### Current File Uploads

| User ID | File Type | File Name | File Description | Upload Date |
|---|---|---|---|---|
| cdomeier | Communication Documentation | 3_PMDL3715_1_3_20160129160524_DY1Q3_absense_of_patient_registry_explanation.docx | Explanation for absence of DY1, Q3 Patient Update | 01/29/2016 04:05 PM |

**Narrative Text :**

For PPS to provide additional context regarding progress and/or updates to IA.

### Module Review Status

| Review Status | IA Formal Comments |
|---|---|
| Fail | The PPS failed to meet at least 80% of its actively engaged commitments for DY1Q3. The documentation does not support the reported actively engaged numbers. |

### NYS Confidentiality – High

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## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 3.a.i.3 - Prescribed Milestones

**Instructions :**

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for prescribed milestones. For milestones that are due and completed within the reporting period, documentation is required to provide evidence of project requirement achievement. Any explanations regarding altered or missed provider commitments should be included within the narrative box, not as text within uploaded documentation.

| Project Requirements (Milestone/Task Name) | Project Model Name | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|---|
| **Milestone #1** Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3. | Model 1 | Project | N/A | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3. | | Provider | Practitioner - Primary Care Provider (PCP) | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** Behavioral health services are co-located within PCMH/APC practices and are available. | | Provider | Mental Health | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 1.Identify project team members from working groups and define roles and responsibilities | | Project | | Completed | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 |
| **Task** 2. Identify a project leader/ champion to spearhead the effort and work collaboratively with the PCMH Project Manager to coordinate efforts to obtain PCMH NCQA level 3 certification | | Project | | Completed | 07/01/2015 | 12/31/2015 | 07/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 |
| **Task** 3. Distribute a survey of interest to primary care sites in the community; identifying interest in the PCMH Collaborative Care Model. | | Project | | Completed | 07/01/2015 | 12/31/2015 | 07/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 |
| **Task** 4. Convene interested providers and sites to review requirements and capabilities to develop a PCMH Collaborative Care Model | | Project | | In Progress | 07/01/2015 | 12/31/2015 | 07/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task** 5. Identify DSRIP project requirements, milestones | | Project | | In Progress | 07/01/2015 | 12/31/2015 | 07/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |

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| Project Requirements (Milestone/Task Name) | Project Model Name | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|---|
| (deliverable), and metrics and build these steps into the project team process. | | | | | | | | | | |
| **Task** 6. Assess each providers capabilities and development/resource needs to meet project requirements and milestones. | | Project | | In Progress | 07/01/2015 | 12/31/2015 | 07/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task** 7. Define future state of colocation of services | | Project | | In Progress | 07/01/2015 | 12/31/2015 | 07/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task** 8. Align plan for PCMH with project 2.a.i (Integrated Delivery System) to ensure that practices will meet NCQA standards and that the timeline for each site is appropriate across projects requiring certification | | Project | | In Progress | 07/01/2015 | 03/31/2016 | 07/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 9. Finalize strategy for achieving PCMH Level 3 certification for contracted providers at PPS level | | Project | | In Progress | 07/01/2015 | 03/31/2016 | 07/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 10. Classify providers according to criteria to their level of NCQA qualification: not recognized, Level 1, 2, and 3 using 2011 standards, and those that are in process of applying for 2014 standards. | | Project | | In Progress | 07/01/2015 | 03/31/2016 | 07/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 11. Engage providers meeting the standards to participate in the model with behavioral health providers. | | Project | | In Progress | 07/01/2015 | 03/31/2016 | 07/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 12. Use evidence-based clinical practices, program design and management approaches where they are available. | | Project | | In Progress | 10/01/2015 | 03/31/2016 | 10/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 13. Coordinate the availability and schedules of behavioral health services and providers to ensure adequate coverage within PCMH practices for the expected volume of patients and hours of service required. | | Project | | In Progress | 01/01/2016 | 03/31/2018 | 01/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 14. For all entities and potential future partner entities document the level of care, scope of services, populations touched and managed, existing contractual arrangements between entities, and State/ Federal regulations related to | | Project | | In Progress | 01/01/2016 | 03/31/2018 | 01/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |

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| Project Requirements (Milestone/Task Name) | Project Model Name | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|---|
| reimbursement and contracting, existing QI processes with compensation based on outcomes and any forays into alternate payment models | | | | | | | | | | |
| **Task**<br>15. Address any legal, financial and contractual issues, regulatory policies, waivers, licensure/certifications to provide co- location of services | | Project | | In Progress | 01/01/2016 | 03/31/2018 | 01/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>16. Convene the project team to develop the collaborative care practices | | Project | | In Progress | 01/01/2016 | 03/31/2018 | 01/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>9-24-15 Remediation Response:<br>17. Develop a project design for providing BH care at the PC sites. This will include the identification & placement of BH providers as well as physicial space within the PC site to perform screening and other services. Where appropriate, the model will include strategies to integrate PC and BH care through best practices such as case conferencing. | | Project | | In Progress | 09/24/2015 | 03/31/2017 | 09/24/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>9-24-15 Remediation Response<br>18. Collaborate with teh worforce team to strategize on recruitment, training, and involvement of behavioral health providers to ensure adequate services are available in the integration sites. Track & monitor workforce enhancements on a regular basis and adjust as needed to ensure success. | | Project | | In Progress | 09/24/2015 | 03/31/2017 | 09/24/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>9-24-15 Remediation Response<br>19. Report progress on all aspects of the project re-desgin, including but not limited to workforce enhancement on a quarterly basis to appropriate project leads, the Board of Managers and committees | | Project | | In Progress | 09/24/2015 | 03/31/2017 | 09/24/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>9-24-15 Remediation Response<br>20. Consider innovative programs, such as partnering with surrounding PPS's, leveraging career development | | Project | | In Progress | 09/24/2015 | 03/31/2017 | 09/24/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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| Project Requirements (Milestone/Task Name) | Project Model Name | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|---|
| programs at area learning institions, utilizing telemedicine avenues, etc...to ehance recruitment & retention of behavioral health providers that will be necessary to ensure success. | | | | | | | | | | |
| **Task** 9-24-15 Remediation Response - Stakeholder Engagment: 21. While we have 35 providers committed, we have more behaviorist within the network to consider for implementation. | | Project | | In Progress | 09/24/2015 | 03/31/2017 | 09/24/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #2** Develop collaborative evidence-based standards of care including medication management and care engagement process. | Model 1 | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** Regularly scheduled formal meetings are held to develop collaborative care practices. | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** Coordinated evidence-based care protocols are in place, including medication management and care engagement processes. | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 1. Establish the project work team that includes PCMH and behavioral health physician representatives, community resources and member advisors. | | Project | | In Progress | 07/01/2015 | 12/31/2015 | 07/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task** 2. Incorporate the identified standards and their sources into the communication action plan for providers. | | Project | | In Progress | 07/01/2015 | 12/31/2015 | 07/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task** 3. Utilize nationally recognized evidence based tools to implement at co-located practices for behavioral health conditions with emphasis on behavioral health treating chronic health conditions | | Project | | In Progress | 07/01/2015 | 07/31/2016 | 07/01/2015 | 07/31/2016 | 09/30/2016 | DY2 Q2 |
| **Task** 4. Present recommendations to the Clinical Integration and Quality committee of the PPS on project methodology | | Project | | In Progress | 07/01/2015 | 07/31/2016 | 07/01/2015 | 07/31/2016 | 09/30/2016 | DY2 Q2 |
| **Task** 5. Implement processes to schedule, conduct and | | Project | | In Progress | 07/01/2015 | 07/03/2016 | 07/01/2015 | 07/03/2016 | 09/30/2016 | DY2 Q2 |

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| Project Requirements (Milestone/Task Name) | Project Model Name | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|---|
| document scheduled formal meetings to develop collaborative care practices and ensure coordinated evidence-based care protocols are in place, including medication management and care engagement processes. | | | | | | | | | | |
| **Task**<br>6. Document the workflow steps including role/responsibility to screen, frequency, documentation, policies/procedures to support 100% colocation | | Project | | In Progress | 07/01/2015 | 03/31/2017 | 07/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>7. Develop the warm hand off process to the behavioral health resource and PCMH feedback process including scripting for communication. | | Project | | In Progress | 07/01/2015 | 03/31/2017 | 07/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>8. Develop means to provide educational/training through learning management system (LMS) on evidence-based tools focusing on behavioral health challenges most commonly seen in primary care | | Project | | In Progress | 07/01/2015 | 03/31/2017 | 07/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>9. Develop the steps to implement tools and processes into PCMH and incorporate with care management; insert steps into the work plan. | | Project | | In Progress | 07/01/2015 | 03/31/2017 | 07/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>10. Track and evaluate programs roll out using rapid cycle team evaluation techniques | | Project | | In Progress | 07/01/2015 | 03/31/2017 | 07/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>11. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | | Project | | In Progress | 07/01/2015 | 03/31/2017 | 07/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #3**<br>Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs. | Model 1 | Project | N/A | In Progress | 04/01/2015 | 03/31/2019 | 04/01/2015 | 03/31/2019 | 03/31/2019 | DY4 Q4 |
| **Task**<br>Policies and procedures are in place to facilitate and document completion of screenings. | | Project | | In Progress | 04/01/2015 | 03/31/2019 | 04/01/2015 | 03/31/2019 | 03/31/2019 | DY4 Q4 |
| **Task** | | Project | | In Progress | 04/01/2015 | 03/30/2019 | 04/01/2015 | 03/30/2019 | 03/31/2019 | DY4 Q4 |

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| Project Requirements (Milestone/Task Name) | Project Model Name | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|---|
| Screenings are documented in Electronic Health Record. | | | | | | | | | | |
| **Task** At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT). | | Project | | In Progress | 04/01/2015 | 03/31/2019 | 04/01/2015 | 03/31/2019 | 03/31/2019 | DY4 Q4 |
| **Task** Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record. | | Provider | Practitioner - Primary Care Provider (PCP) | In Progress | 04/01/2015 | 03/31/2019 | 04/01/2015 | 03/31/2019 | 03/31/2019 | DY4 Q4 |
| **Task** 1. Complete assessment to determine which preventive behavioral health screenings are currently used at each PCP sites | | Project | | Completed | 07/01/2015 | 12/31/2015 | 07/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 |
| **Task** 2. Include representatives from practices and the IT project team to identify feasibility to integrate a user friendly screening tools into EMR and practices | | Project | | In Progress | 07/01/2015 | 03/31/2016 | 07/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 3. Develop methods to document number of clients screened via alternate techniques until IT solutions in place | | Project | | In Progress | 07/01/2015 | 03/31/2019 | 07/01/2015 | 03/31/2019 | 03/31/2019 | DY4 Q4 |
| **Task** 4. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | | Project | | In Progress | 07/01/2015 | 03/31/2019 | 07/01/2015 | 03/31/2019 | 03/31/2019 | DY4 Q4 |
| **Task** 5. Outline the workflow steps including role/responsibility to screen, frequency, documentation, policies/procedures to support client screening | | Project | | In Progress | 09/01/2015 | 03/31/2016 | 09/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 6. Outline the workflow steps from screening completion to include result evaluation, patient communication scripting, provider review, referral triggers, referral process and documentation | | Project | | In Progress | 09/01/2015 | 03/31/2017 | 09/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 7. Define process for handling patients that are deemed at-risk based on the screen, including behavioral health | | Project | | In Progress | 09/01/2015 | 03/31/2017 | 09/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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| Project Requirements (Milestone/Task Name) | Project Model Name | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|---|
| interventions | | | | | | | | | | |
| **Task** 8. Define process for documenting results in EHR for patients that are deemed at-risk based on the screening | | Project | | In Progress | 09/01/2015 | 03/31/2017 | 09/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 9. Establish the warm hand off process to the behavioral health resource and PCMH feedback process including patient scripting for communication. | | Project | | In Progress | 09/01/2015 | 03/31/2017 | 09/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 10. Implement evidence based practices for clinical screenings | | Project | | In Progress | 03/01/2016 | 03/31/2019 | 03/01/2016 | 03/31/2019 | 03/31/2019 | DY4 Q4 |
| **Task** 11 Track and evaluate programs roll out using rapid cycle team evaluation techniques | | Project | | In Progress | 03/01/2016 | 03/31/2019 | 03/01/2016 | 03/31/2019 | 03/31/2019 | DY4 Q4 |
| **Milestone #4** Use EHRs or other technical platforms to track all patients engaged in this project. | Model 1 | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** EHR demonstrates integration of medical and behavioral health record within individual patient records. | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 1. Determine requirements for identification of targeted patients and tracking actively engaged patients per state-provided specifications for the DSRIP program. | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 2. Review strategies and tools needed to promote DSRIP specific Patient Engagement | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 3. Working with the project team document current and future state work flow in addition to capturing manual solutions in place at this time. | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 4. Assess current EHR and other technical platforms in the PPS against established requirements for patient identification and tracking, system notification, and | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Project Model Name | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|---|
| treatment plan creation. | | | | | | | | | | |
| **Task** 5. Create a gap analysis based on the work flow analysis to determine incremental IT needs and associated budget, including short-term manual solutions. | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 6. Identify prioritization of systems to build or associated change with separate work streams focused on implementing new Electronic Health Record Systems vs. RHIO connectivity based on the DSRIP project needs and associated providers' needs | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 7. Develop a roll-out plan for systems to achieve clinical data sharing, including a training plan to support the successful implementation of new platforms and processes | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 8. Establish a process for monitoring project milestones and performance | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 9. Where electronic functionality is not yet ready, implement alternate in the interim and track conversion to electronic systems. | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 10. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS. | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 11. Develop a process for determining how success will be measured that incorporates feedback from practitioners and other key users of IT, including financial and patient engagement impact and risks. | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #5** Co-locate primary care services at behavioral health sites. | Model 2 | Project | N/A | In Progress | 04/01/2015 | 03/31/2019 | 04/01/2015 | 03/31/2019 | 03/31/2019 | DY4 Q4 |
| **Task** PPS has achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3. | | Provider | Practitioner - Primary Care Provider (PCP) | In Progress | 04/01/2015 | 03/31/2019 | 04/01/2015 | 03/31/2019 | 03/31/2019 | DY4 Q4 |
| **Task** Primary care services are co-located within behavioral | | Provider | Practitioner - Primary | In Progress | 04/01/2015 | 03/31/2019 | 04/01/2015 | 03/31/2019 | 03/31/2019 | DY4 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Project Model Name | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|---|
| Health practices and are available. | | | Care Provider (PCP) | | | | | | | |
| **Task** Primary care services are co-located within behavioral Health practices and are available. | | Provider | Mental Health | In Progress | 04/01/2015 | 03/31/2019 | 04/01/2015 | 03/31/2019 | 03/31/2019 | DY4 Q4 |
| **Task** 1. Distribute a survey of interest to behavioral service sites in the community; identify interest in the Behavioral Health Collaborative Care Model. | | Project | | Completed | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 |
| **Task** 2. Convene interested providers and sites to review requirements and capabilities to develop a Behavioral Health Service Site model. | | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task** 3. Identify model project requirements, milestones (deliverables), and metrics and build these steps into the project team process | | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task** 4. Identify those providers that are co-located and secure legal advice to address any identified licensure issues. | | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 5. Assess each partner's capabilities and development/resource needs to meet project requirements and milestones. | | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task** 6. Define future state of colocation of services | | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task** 7. Use evidence-based clinical practices, program design and management approaches where they are available. | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 8. Align plan for PCMH with project 2.a.i (Integrated Delivery System) to ensure that practices will meet NCQA standards and that the timeline for each site is appropriate across projects requiring certification | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 9. Convene community, facility and PPS governance representatives to review PPS program structure, MOUs, financial plan and regulatory requirements for the Behavioral Health Site model structure | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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| Project Requirements (Milestone/Task Name) | Project Model Name | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task** 10. Engage providers meeting the standards to participate in the model with behavioral health providers | | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 11. Develop support and training modules for collaboration of providers and integration of roles | | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 12. Classify providers according to criteria to their level of NCQA qualification: not recognized, Level 1, 2, and 3 using 2011 standards, and those that are in process of applying for 2014 standards. | | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 13. Engage providers meeting the standards to participate in the model with PCP and PCMH providers | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 14. Coordinate the availability and schedules of behavioral health services and providers to ensure adequate coverage within PCMH practices for the expected volume of patients and hours of service required. | | Project | | In Progress | 04/01/2015 | 03/31/2019 | 04/01/2015 | 03/31/2019 | 03/31/2019 | DY4 Q4 |
| **Task** 15. For all entities and potential future partner entities document the level of care, scope of services, populations touched and managed, existing contractual arrangements between entities, and State/ Federal regulations related to reimbursement and contracting, existing QI processes with compensation based on outcomes and any forays into alternate payment models | | Project | | In Progress | 04/01/2015 | 03/31/2019 | 04/01/2015 | 03/31/2019 | 03/31/2019 | DY4 Q4 |
| **Task** 16. Address any legal, financial and contractual issues, regulatory policies, waivers, licensure/certifications to provide co- location of services | | Project | | In Progress | 04/01/2015 | 03/31/2019 | 04/01/2015 | 03/31/2019 | 03/31/2019 | DY4 Q4 |
| **Task** 17. Convene the project team to develop the collaborative care practices | | Project | | In Progress | 04/01/2015 | 03/31/2019 | 04/01/2015 | 03/31/2019 | 03/31/2019 | DY4 Q4 |
| **Task** 9-24-15 Remediation Response: 18. Develop an overall program design & approach | | Project | | In Progress | 09/24/2015 | 03/31/2019 | 09/24/2015 | 03/31/2019 | 03/31/2019 | DY4 Q4 |

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| Project Requirements (Milestone/Task Name) | Project Model Name | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|---|
| (including generic work flow) to provide primary care within the BH settting in an integrated manner. | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response:<br>19. Strategize with the Clinical LeadershipCouncil, Clinical Integration Conmmittee, CBO's and other relevant stakeholders to collaborate and include internal and external stakeholders in leveraging BH and SUD providers to particpate in co-location. | | Project | | In Progress | 09/24/2015 | 03/31/2019 | 09/24/2015 | 03/31/2019 | 03/31/2019 | DY4 Q4 |
| **Task**<br>9-24-15 Remediation Response:<br>20. Develop timeline for workforce recrutiment strategy. Incorporate CBOs as key stakeholders in model development and execution. | | Project | | In Progress | 09/24/2015 | 03/31/2017 | 09/24/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>9-24-15 Remediation Response<br>21. Assess current state BH & SUD provider sites to identify opportunities to co-locate care and services using the Collaborative Care Model | | Project | | In Progress | 09/24/2015 | 03/31/2016 | 09/24/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task**<br>9-24-15 Remediation Response<br>22. Identify primary care providers through stakeholder engagemnt that will particpate in screening and referral processes for BH and SUD referrals. Refer to lead health homes for additional BH care managment support and verify capacity of health homesis sufficient to handle all referrals. | | Project | | In Progress | 09/24/2015 | 03/31/2017 | 09/24/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>9-24-15 Remediation Response<br>23. Evaluate success of the program based on achievement of Domain 1 metrics and improved outcomes. Develop and produce quarterly outcomes dashboards for project teams, CIQC and Goverance committees to track program success and respond to opportunites for improvment when appropriate. | | Project | | In Progress | 09/24/2015 | 07/31/2016 | 09/24/2015 | 07/31/2016 | 09/30/2016 | DY2 Q2 |
| **Milestone #6**<br>Develop collaborative evidence-based standards of care | Model 2 | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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| Project Requirements (Milestone/Task Name) | Project Model Name | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|---|
| including medication management and care engagement process. | | | | | | | | | | |
| **Task** Regularly scheduled formal meetings are held to develop collaborative care practices. | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** Coordinated evidence-based care protocols are in place, including a medication management and care engagement process. | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 1. Establish the project work team that includes PCMH and behavioral health physician representatives, community resources and member advisors. | | Project | | In Progress | 07/01/2015 | 12/31/2015 | 07/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task** 2. Incorporate the identified standards and their sources into the communication action plan for providers | | Project | | In Progress | 07/01/2015 | 12/31/2015 | 07/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task** 3. Utilize nationally recognized evidence based tools to implement at co-located practices for primary care, preventative conditions and chronic health conditions. | | Project | | In Progress | 07/01/2015 | 07/31/2016 | 07/01/2015 | 07/31/2016 | 09/30/2016 | DY2 Q2 |
| **Task** 4. Present recommendations to the Clinical Integration and Quality committee of the PPS on project methodology | | Project | | In Progress | 07/01/2015 | 07/31/2016 | 07/01/2015 | 07/31/2016 | 09/30/2016 | DY2 Q2 |
| **Task** 5. Implement processes to schedule, conduct and document scheduled formal meetings to develop collaborative care practices and ensure coordinated evidence-based care protocols are in place, including medication management and care engagement processes. | | Project | | In Progress | 07/01/2015 | 07/31/2016 | 07/01/2015 | 07/31/2016 | 09/30/2016 | DY2 Q2 |
| **Task** 6. Document the workflow steps including role/responsibility to screen, frequency, documentation, policies/procedures to support 100% colocation | | Project | | In Progress | 07/01/2015 | 03/31/2017 | 07/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 7. Develop the warm hand off process to the PCP resource and behavioral health feedback process including scripting for communication | | Project | | In Progress | 07/01/2015 | 03/31/2017 | 07/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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| Project Requirements (Milestone/Task Name) | Project Model Name | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task** 8. Develop means to provide educational/training through learning management system (LMS) on evidence-based tools focusing on behavioral health challenges most commonly seen in behavioral health | | Project | | In Progress | 07/01/2015 | 03/31/2017 | 07/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 9. Develop the steps to implement tools and processes into behavioral health services and incorporate with care management; insert steps into the work plan. | | Project | | In Progress | 07/01/2015 | 03/31/2017 | 07/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 10. Track and evaluate programs roll out using rapid cycle team evaluation techniques | | Project | | In Progress | 07/01/2015 | 03/31/2017 | 07/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 11. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | | Project | | In Progress | 07/01/2015 | 03/31/2017 | 07/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #7** Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs. | Model 2 | Project | N/A | In Progress | 04/01/2015 | 03/31/2019 | 04/01/2015 | 03/31/2019 | 03/31/2019 | DY4 Q4 |
| **Task** Screenings are conducted for all patients. Process workflows and operational protocols are in place to implement and document screenings. | | Project | | In Progress | 04/01/2015 | 03/31/2019 | 04/01/2015 | 03/31/2019 | 03/31/2019 | DY4 Q4 |
| **Task** Screenings are documented in Electronic Health Record. | | Project | | In Progress | 04/01/2015 | 03/31/2019 | 04/01/2015 | 03/31/2019 | 03/31/2019 | DY4 Q4 |
| **Task** At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT). | | Project | | In Progress | 04/01/2015 | 03/31/2019 | 04/01/2015 | 03/31/2019 | 03/31/2019 | DY4 Q4 |
| **Task** Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record. | | Provider | Practitioner - Primary Care Provider (PCP) | In Progress | 04/01/2015 | 03/31/2019 | 04/01/2015 | 03/31/2019 | 03/31/2019 | DY4 Q4 |
| **Task** 1. Complete assessment to determine which preventive | | Project | | Completed | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 |

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| Project Requirements (Milestone/Task Name) | Project Model Name | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|---|
| behavioral health screenings are currently used at each behavioral health services sites | | | | | | | | | | |
| **Task** 2. Include representatives from practices and the IT project team to identify a user friendly approach to integrate screening tools into EMR and practices | | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 3. Outline the workflow steps including role/responsibility to screen, frequency, documentation, policies/procedures to support client screening | | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 4. Outline the workflow steps from screening completion to include result evaluation, patient communication scripting, provider review, referral triggers, referral process and documentation | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 5. Define process for handling patients that are deemed at-risk based on the screen, including behavioral health interventions | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 6. Define process for documenting results in EHR for patients that are deemed at-risk based on the screening | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 7. Establish the warm hand off process to the PCP resource and behavioral health feedback process including patient scripting for communication | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 8. Implement evidence based screenings and brief intervention processes | | Project | | In Progress | 04/01/2015 | 03/31/2019 | 04/01/2015 | 03/31/2019 | 03/31/2019 | DY4 Q4 |
| **Task** 9. Track and evaluate programs roll out using rapid cycle team evaluation techniques | | Project | | In Progress | 04/01/2015 | 03/31/2019 | 04/01/2015 | 03/31/2019 | 03/31/2019 | DY4 Q4 |
| **Task** 10. Develop methods to document number of clients screened via alternate techniques until IT solutions in place | | Project | | In Progress | 04/01/2015 | 03/31/2019 | 04/01/2015 | 03/31/2019 | 03/31/2019 | DY4 Q4 |
| **Task** 11. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when | | Project | | In Progress | 04/01/2015 | 03/31/2019 | 04/01/2015 | 03/31/2019 | 03/31/2019 | DY4 Q4 |

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| Project Requirements (Milestone/Task Name) | Project Model Name | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|---|
| indicated | | | | | | | | | | |
| **Milestone #8** Use EHRs or other technical platforms to track all patients engaged in this project. | Model 2 | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** EHR demonstrates integration of medical and behavioral health record within individual patient records. | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 1. Determine requirements for identification of targeted patients and tracking actively engaged patients per state-provided specifications for the DSRIP program. | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 2. Review strategies and tools needed to promote DSRIP specific Patient Engagement | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 3. Working with the project team document current and future state work flow in addition to capturing manual solutions in place at this time. | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 4. Assess current EHR and other technical platforms in the PPS against established requirements for patient identification and tracking, system notification, and treatment plan creation. | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 5. Create a gap analysis based on the work flow analysis to determine incremental IT needs and associated budget, including short-term manual solutions. | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 6. Identify prioritization of systems to build or associated change with separate work streams focused on implementing new Electronic Health Record Systems vs. RHIO connectivity based on the DSRIP project needs and associated providers' needs | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 7. Develop a roll-out plan for systems to achieve clinical | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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| Project Requirements (Milestone/Task Name) | Project Model Name | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|---|
| data sharing, including a training plan to support the successful implementation of new platforms and processes | | | | | | | | | | |
| **Task** 8. Establish a process for monitoring project milestones and performance. | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 9. Where electronic functionality is not yet ready, implement alternate in the interim and track conversion to electronic systems. | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 10. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS. | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 11. Develop a process for determining how success will be measured that incorporates feedback from practitioners and other key users of IT, including financial and patient engagement impact and risks. | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #9** Implement IMPACT Model at Primary Care Sites. | Model 3 | Project | N/A | On Hold | 04/01/2015 | 03/31/2020 | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** PPS has implemented IMPACT Model at Primary Care Sites. | | Provider | Practitioner - Primary Care Provider (PCP) | On Hold | 04/01/2015 | 03/31/2020 | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #10** Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement. | Model 3 | Project | N/A | On Hold | 04/01/2015 | 03/31/2020 | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Coordinated evidence-based care protocols are in place, including a medication management and care engagement process to facilitate collaboration between primary care physician and care manager. | | Project | | On Hold | 04/01/2015 | 03/31/2020 | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Policies and procedures include process for consulting with Psychiatrist. | | Project | | On Hold | 04/01/2015 | 03/31/2020 | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #11** Employ a trained Depression Care Manager meeting requirements of the IMPACT model. | Model 3 | Project | N/A | On Hold | 04/01/2015 | 03/31/2020 | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

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|---|---|---|---|---|---|---|---|---|---|---|
| **Task** PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records. | | Project | | On Hold | 04/01/2015 | 03/31/2020 | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Depression care manager meets requirements of IMPACT model, including coaching patients in behavioral activation, offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan. | | Project | | On Hold | 04/01/2015 | 03/31/2020 | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #12** Designate a Psychiatrist meeting requirements of the IMPACT Model. | Model 3 | Project | N/A | On Hold | 04/01/2015 | 03/31/2020 | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** All IMPACT participants in PPS have a designated Psychiatrist. | | Project | | On Hold | 04/01/2015 | 03/31/2020 | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #13** Measure outcomes as required in the IMPACT Model. | Model 3 | Project | N/A | On Hold | 04/01/2015 | 03/31/2020 | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT). | | Project | | On Hold | 04/01/2015 | 03/31/2020 | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #14** Provide "stepped care" as required by the IMPACT Model. | Model 3 | Project | N/A | On Hold | 04/01/2015 | 03/31/2020 | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm that includes evaluation of patient after 10-12 weeks after start of treatment plan. | | Project | | On Hold | 04/01/2015 | 03/31/2020 | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #15** Use EHRs or other technical platforms to track all patients engaged in this project. | Model 3 | Project | N/A | On Hold | 04/01/2015 | 03/31/2020 | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** EHR demonstrates integration of medical and behavioral health record within individual patient records. | | Project | | On Hold | 04/01/2015 | 03/31/2020 | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** PPS identifies targeted patients and is able to track actively | | Project | | On Hold | 04/01/2015 | 03/31/2020 | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Project Model Name | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|---|
| engaged patients for project milestone reporting. | | | | | | | | | | |

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Milestone #1** Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3. | | | | | | | | | | |
| **Task** All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 33 | 78 |
| **Task** Behavioral health services are co-located within PCMH/APC practices and are available. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 6 | 14 |
| **Task** 1.Identify project team members from working groups and define roles and responsibilities | | | | | | | | | | |
| **Task** 2. Identify a project leader/ champion to spearhead the effort and work collaboratively with the PCMH Project Manager to coordinate efforts to obtain PCMH NCQA level 3 certification | | | | | | | | | | |
| **Task** 3. Distribute a survey of interest to primary care sites in the community; identifying interest in the PCMH Collaborative Care Model. | | | | | | | | | | |
| **Task** 4. Convene interested providers and sites to review requirements and capabilities to develop a PCMH Collaborative Care Model | | | | | | | | | | |
| **Task** 5. Identify DSRIP project requirements, milestones (deliverable), and metrics and build these steps into the project team process. | | | | | | | | | | |
| **Task** 6. Assess each providers capabilities and development/resource needs to meet project requirements and milestones. | | | | | | | | | | |
| **Task** 7. Define future state of colocation of services | | | | | | | | | | |
| **Task** 8. Align plan for PCMH with project 2.a.i (Integrated Delivery System) to ensure that practices will meet NCQA standards and that the timeline for each site is appropriate across projects | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| requiring certification | | | | | | | | | | |
| **Task**<br>9. Finalize strategy for achieving PCMH Level 3 certification for contracted providers at PPS level | | | | | | | | | | |
| **Task**<br>10. Classify providers according to criteria to their level of NCQA qualification: not recognized, Level 1, 2, and 3 using 2011 standards, and those that are in process of applying for 2014 standards. | | | | | | | | | | |
| **Task**<br>11. Engage providers meeting the standards to participate in the model with behavioral health providers. | | | | | | | | | | |
| **Task**<br>12. Use evidence-based clinical practices, program design and management approaches where they are available. | | | | | | | | | | |
| **Task**<br>13. Coordinate the availability and schedules of behavioral health services and providers to ensure adequate coverage within PCMH practices for the expected volume of patients and hours of service required. | | | | | | | | | | |
| **Task**<br>14. For all entities and potential future partner entities document the level of care, scope of services, populations touched and managed, existing contractual arrangements between entities, and State/ Federal regulations related to reimbursement and contracting, existing QI processes with compensation based on outcomes and any forays into alternate payment models | | | | | | | | | | |
| **Task**<br>15. Address any legal, financial and contractual issues, regulatory policies, waivers, licensure/certifications to provide co-location of services | | | | | | | | | | |
| **Task**<br>16. Convene the project team to develop the collaborative care practices | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response:<br>17. Develop a project design for providing BH care at the PC sites. This will include the identification & placement of BH providers as well as physicial space within the PC site to perform screening and other services. Where appropriate, the model will include strategies to integrate PC and BH care through best practices such as case conferencing. | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| 18. Collaborate with teh worforce team to strategize on recruitment, training, and involvement of behavioral health providers to ensure adequate services are available in the integration sites. Track & monitor workforce enhancements on a regular basis and adjust as needed to ensure success. | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>19. Report progress on all aspects of the project re-desgin, including but not limited to workforce enhancement on a quarterly basis to appropriate project leads, the Board of Managers and committees | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>20. Consider innovative programs, such as partnering with surrounding PPS's, leveraging career development programs at area learning institions, utilizing telemedicine avenues, etc...to ehance recruitment & retention of behavioral health providers that will be necessary to ensure success. | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response - Stakeholder Engagment:<br>21. While we have 35 providers committed, we have more behaviorist within the network to consider for implementation. | | | | | | | | | | |
| **Milestone #2**<br>Develop collaborative evidence-based standards of care including medication management and care engagement process. | | | | | | | | | | |
| **Task**<br>Regularly scheduled formal meetings are held to develop collaborative care practices. | | | | | | | | | | |
| **Task**<br>Coordinated evidence-based care protocols are in place, including medication management and care engagement processes. | | | | | | | | | | |
| **Task**<br>1. Establish the project work team that includes PCMH and behavioral health physician representatives, community resources and member advisors. | | | | | | | | | | |
| **Task**<br>2. Incorporate the identified standards and their sources into the communication action plan for providers. | | | | | | | | | | |
| **Task**<br>3. Utilize nationally recognized evidence based tools to implement at co-located practices for behavioral health conditions with emphasis on behavioral health treating chronic health conditions | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task** 4. Present recommendations to the Clinical Integration and Quality committee of the PPS on project methodology | | | | | | | | | | |
| **Task** 5. Implement processes to schedule, conduct and document scheduled formal meetings to develop collaborative care practices and ensure coordinated evidence-based care protocols are in place, including medication management and care engagement processes. | | | | | | | | | | |
| **Task** 6. Document the workflow steps including role/responsibility to screen, frequency, documentation, policies/procedures to support 100% colocation | | | | | | | | | | |
| **Task** 7. Develop the warm hand off process to the behavioral health resource and PCMH feedback process including scripting for communication. | | | | | | | | | | |
| **Task** 8. Develop means to provide educational/training through learning management system (LMS) on evidence-based tools focusing on behavioral health challenges most commonly seen in primary care | | | | | | | | | | |
| **Task** 9. Develop the steps to implement tools and processes into PCMH and incorporate with care management; insert steps into the work plan. | | | | | | | | | | |
| **Task** 10. Track and evaluate programs roll out using rapid cycle team evaluation techniques | | | | | | | | | | |
| **Task** 11. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | | | | | | | | | | |
| **Milestone #3** Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs. | | | | | | | | | | |
| **Task** Policies and procedures are in place to facilitate and document completion of screenings. | | | | | | | | | | |
| **Task** Screenings are documented in Electronic Health Record. | | | | | | | | | | |
| **Task** At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| SBIRT). | | | | | | | | | | |
| **Task** Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 12 | 27 |
| **Task** 1. Complete assessment to determine which preventive behavioral health screenings are currently used at each PCP sites | | | | | | | | | | |
| **Task** 2. Include representatives from practices and the IT project team to identify feasibility to integrate a user friendly screening tools into EMR and practices | | | | | | | | | | |
| **Task** 3. Develop methods to document number of clients screened via alternate techniques until IT solutions in place | | | | | | | | | | |
| **Task** 4. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | | | | | | | | | | |
| **Task** 5. Outline the workflow steps including role/responsibility to screen, frequency, documentation, policies/procedures to support client screening | | | | | | | | | | |
| **Task** 6. Outline the workflow steps from screening completion to include result evaluation, patient communication scripting, provider review, referral triggers, referral process and documentation | | | | | | | | | | |
| **Task** 7. Define process for handling patients that are deemed at-risk based on the screen, including behavioral health interventions | | | | | | | | | | |
| **Task** 8. Define process for documenting results in EHR for patients that are deemed at-risk based on the screening | | | | | | | | | | |
| **Task** 9. Establish the warm hand off process to the behavioral health resource and PCMH feedback process including patient scripting for communication. | | | | | | | | | | |
| **Task** 10. Implement evidence based practices for clinical screenings | | | | | | | | | | |
| **Task** 11 Track and evaluate programs roll out using rapid cycle team evaluation techniques | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Milestone #4** Use EHRs or other technical platforms to track all patients engaged in this project. | | | | | | | | | | |
| **Task** EHR demonstrates integration of medical and behavioral health record within individual patient records. | | | | | | | | | | |
| **Task** PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. | | | | | | | | | | |
| **Task** 1. Determine requirements for identification of targeted patients and tracking actively engaged patients per state-provided specifications for the DSRIP program. | | | | | | | | | | |
| **Task** 2. Review strategies and tools needed to promote DSRIP specific Patient Engagement | | | | | | | | | | |
| **Task** 3. Working with the project team document current and future state work flow in addition to capturing manual solutions in place at this time. | | | | | | | | | | |
| **Task** 4. Assess current EHR and other technical platforms in the PPS against established requirements for patient identification and tracking, system notification, and treatment plan creation. | | | | | | | | | | |
| **Task** 5. Create a gap analysis based on the work flow analysis to determine incremental IT needs and associated budget, including short-term manual solutions. | | | | | | | | | | |
| **Task** 6. Identify prioritization of systems to build or associated change with separate work streams focused on implementing new Electronic Health Record Systems vs. RHIO connectivity based on the DSRIP project needs and associated providers' needs | | | | | | | | | | |
| **Task** 7. Develop a roll-out plan for systems to achieve clinical data sharing, including a training plan to support the successful implementation of new platforms and processes | | | | | | | | | | |
| **Task** 8. Establish a process for monitoring project milestones and performance | | | | | | | | | | |
| **Task** 9. Where electronic functionality is not yet ready, implement alternate in the interim and track conversion to electronic systems. | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task** 10. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS. | | | | | | | | | | |
| **Task** 11. Develop a process for determining how success will be measured that incorporates feedback from practitioners and other key users of IT, including financial and patient engagement impact and risks. | | | | | | | | | | |
| **Milestone #5** Co-locate primary care services at behavioral health sites. | | | | | | | | | | |
| **Task** PPS has achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 12 | 27 |
| **Task** Primary care services are co-located within behavioral Health practices and are available. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 12 | 27 |
| **Task** Primary care services are co-located within behavioral Health practices and are available. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 5 |
| **Task** 1. Distribute a survey of interest to behavioral service sites in the community; identify interest in the Behavioral Health Collaborative Care Model. | | | | | | | | | | |
| **Task** 2. Convene interested providers and sites to review requirements and capabilities to develop a Behavioral Health Service Site model. | | | | | | | | | | |
| **Task** 3. Identify model project requirements, milestones (deliverables), and metrics and build these steps into the project team process | | | | | | | | | | |
| **Task** 4. Identify those providers that are co-located and secure legal advice to address any identified licensure issues. | | | | | | | | | | |
| **Task** 5. Assess each partner's capabilities and development/resource needs to meet project requirements and milestones. | | | | | | | | | | |
| **Task** 6. Define future state of colocation of services | | | | | | | | | | |
| **Task** 7. Use evidence-based clinical practices, program design and management approaches where they are available. | | | | | | | | | | |
| **Task** 8. Align plan for PCMH with project 2.a.i (Integrated Delivery System) to ensure that practices will meet NCQA standards and | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| that the timeline for each site is appropriate across projects requiring certification | | | | | | | | | | |
| **Task** 9. Convene community, facility and PPS governance representatives to review PPS program structure, MOUs, financial plan and regulatory requirements for the Behavioral Health Site model structure | | | | | | | | | | |
| **Task** 10. Engage providers meeting the standards to participate in the model with behavioral health providers | | | | | | | | | | |
| **Task** 11. Develop support and training modules for collaboration of providers and integration of roles | | | | | | | | | | |
| **Task** 12. Classify providers according to criteria to their level of NCQA qualification: not recognized, Level 1, 2, and 3 using 2011 standards, and those that are in process of applying for 2014 standards. | | | | | | | | | | |
| **Task** 13. Engage providers meeting the standards to participate in the model with PCP and PCMH providers | | | | | | | | | | |
| **Task** 14. Coordinate the availability and schedules of behavioral health services and providers to ensure adequate coverage within PCMH practices for the expected volume of patients and hours of service required. | | | | | | | | | | |
| **Task** 15. For all entities and potential future partner entities document the level of care, scope of services, populations touched and managed, existing contractual arrangements between entities, and State/ Federal regulations related to reimbursement and contracting, existing QI processes with compensation based on outcomes and any forays into alternate payment models | | | | | | | | | | |
| **Task** 16. Address any legal, financial and contractual issues, regulatory policies, waivers, licensure/certifications to provide co-location of services | | | | | | | | | | |
| **Task** 17. Convene the project team to develop the collaborative care practices | | | | | | | | | | |
| **Task** 9-24-15 Remediation Response: 18. Develop an overall program design & approach (including generic work flow) to provide primary care within the BH settting in an integrated manner. | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>9-24-15 Remediation Response:<br>19. Strategize with the Clinical LeadershipCouncil, Clinical Integration Conmmittee, CBO's and other relevant stakeholders to collaborate and include internal and external stakeholders in leveraging BH and SUD providers to particpate in co-location. | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response:<br>20. Develop timeline for workforce recrutiment strategy. Incorporate CBOs as key stakeholders in model development and execution. | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>21. Assess current state BH & SUD provider sites to identify opportunities to co-locate care and services using the Collaborative Care Model | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>22. Identify primary care providers through stakeholder engagemnt that will particpate in screening and referral processes for BH and SUD referrals. Refer to lead health homes for additional BH care managment support and verify capacity of health homesis sufficient to handle all referrals. | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>23. Evaluate success of the program based on achievement of Domain 1 metrics and improved outcomes. Develop and produce quarterly outcomes dashboards for project teams, CIQC and Goverance committees to track program success and respond to opportunites for improvment when appropriate. | | | | | | | | | | |
| **Milestone #6**<br>Develop collaborative evidence-based standards of care including medication management and care engagement process. | | | | | | | | | | |
| **Task**<br>Regularly scheduled formal meetings are held to develop collaborative care practices. | | | | | | | | | | |
| **Task**<br>Coordinated evidence-based care protocols are in place, including a medication management and care engagement process. | | | | | | | | | | |
| **Task**<br>1. Establish the project work team that includes PCMH and behavioral health physician representatives, community resources and member advisors. | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task** 2. Incorporate the identified standards and their sources into the communication action plan for providers | | | | | | | | | | |
| **Task** 3. Utilize nationally recognized evidence based tools to implement at co-located practices for primary care, preventative conditions and chronic health conditions. | | | | | | | | | | |
| **Task** 4. Present recommendations to the Clinical Integration and Quality committee of the PPS on project methodology | | | | | | | | | | |
| **Task** 5. Implement processes to schedule, conduct and document scheduled formal meetings to develop collaborative care practices and ensure coordinated evidence-based care protocols are in place, including medication management and care engagement processes. | | | | | | | | | | |
| **Task** 6. Document the workflow steps including role/responsibility to screen, frequency, documentation, policies/procedures to support 100% colocation | | | | | | | | | | |
| **Task** 7. Develop the warm hand off process to the PCP resource and behavioral health feedback process including scripting for communication | | | | | | | | | | |
| **Task** 8. Develop means to provide educational/training through learning management system (LMS) on evidence-based tools focusing on behavioral health challenges most commonly seen in behavioral health | | | | | | | | | | |
| **Task** 9. Develop the steps to implement tools and processes into behavioral health services and incorporate with care management; insert steps into the work plan. | | | | | | | | | | |
| **Task** 10. Track and evaluate programs roll out using rapid cycle team evaluation techniques | | | | | | | | | | |
| **Task** 11. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | | | | | | | | | | |
| **Milestone #7** Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs. | | | | | | | | | | |
| **Task** Screenings are conducted for all patients. Process workflows | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| and operational protocols are in place to implement and document screenings. | | | | | | | | | | |
| **Task** Screenings are documented in Electronic Health Record. | | | | | | | | | | |
| **Task** At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT). | | | | | | | | | | |
| **Task** Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 12 | 27 |
| **Task** 1. Complete assessment to determine which preventive behavioral health screenings are currently used at each behavioral health services sites | | | | | | | | | | |
| **Task** 2. Include representatives from practices and the IT project team to identify a user friendly approach to integrate screening tools into EMR and practices | | | | | | | | | | |
| **Task** 3. Outline the workflow steps including role/responsibility to screen, frequency, documentation, policies/procedures to support client screening | | | | | | | | | | |
| **Task** 4. Outline the workflow steps from screening completion to include result evaluation, patient communication scripting, provider review, referral triggers, referral process and documentation | | | | | | | | | | |
| **Task** 5. Define process for handling patients that are deemed at-risk based on the screen, including behavioral health interventions | | | | | | | | | | |
| **Task** 6. Define process for documenting results in EHR for patients that are deemed at-risk based on the screening | | | | | | | | | | |
| **Task** 7. Establish the warm hand off process to the PCP resource and behavioral health feedback process including patient scripting for communication | | | | | | | | | | |
| **Task** 8. Implement evidence based screenings and brief intervention processes | | | | | | | | | | |
| **Task** 9. Track and evaluate programs roll out using rapid cycle team | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| evaluation techniques | | | | | | | | | | |
| **Task** 10. Develop methods to document number of clients screened via alternate techniques until IT solutions in place | | | | | | | | | | |
| **Task** 11. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | | | | | | | | | | |
| **Milestone #8** Use EHRs or other technical platforms to track all patients engaged in this project. | | | | | | | | | | |
| **Task** EHR demonstrates integration of medical and behavioral health record within individual patient records. | | | | | | | | | | |
| **Task** PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. | | | | | | | | | | |
| **Task** 1. Determine requirements for identification of targeted patients and tracking actively engaged patients per state-provided specifications for the DSRIP program. | | | | | | | | | | |
| **Task** 2. Review strategies and tools needed to promote DSRIP specific Patient Engagement | | | | | | | | | | |
| **Task** 3. Working with the project team document current and future state work flow in addition to capturing manual solutions in place at this time. | | | | | | | | | | |
| **Task** 4. Assess current EHR and other technical platforms in the PPS against established requirements for patient identification and tracking, system notification, and treatment plan creation. | | | | | | | | | | |
| **Task** 5. Create a gap analysis based on the work flow analysis to determine incremental IT needs and associated budget, including short-term manual solutions. | | | | | | | | | | |
| **Task** 6. Identify prioritization of systems to build or associated change with separate work streams focused on implementing new Electronic Health Record Systems vs. RHIO connectivity based on the DSRIP project needs and associated providers' needs | | | | | | | | | | |
| **Task** 7. Develop a roll-out plan for systems to achieve clinical data sharing, including a training plan to support the successful implementation of new platforms and processes | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>8. Establish a process for monitoring project milestones and performance. | | | | | | | | | | |
| **Task**<br>9. Where electronic functionality is not yet ready, implement alternate in the interim and track conversion to electronic systems. | | | | | | | | | | |
| **Task**<br>10. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS. | | | | | | | | | | |
| **Task**<br>11. Develop a process for determining how success will be measured that incorporates feedback from practitioners and other key users of IT, including financial and patient engagement impact and risks. | | | | | | | | | | |
| **Milestone #9**<br>Implement IMPACT Model at Primary Care Sites. | | | | | | | | | | |
| **Task**<br>PPS has implemented IMPACT Model at Primary Care Sites. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Milestone #10**<br>Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement. | | | | | | | | | | |
| **Task**<br>Coordinated evidence-based care protocols are in place, including a medication management and care engagement process to facilitate collaboration between primary care physician and care manager. | | | | | | | | | | |
| **Task**<br>Policies and procedures include process for consulting with Psychiatrist. | | | | | | | | | | |
| **Milestone #11**<br>Employ a trained Depression Care Manager meeting requirements of the IMPACT model. | | | | | | | | | | |
| **Task**<br>PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records. | | | | | | | | | | |
| **Task**<br>Depression care manager meets requirements of IMPACT model, including coaching patients in behavioral activation, offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan. | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Milestone #12** Designate a Psychiatrist meeting requirements of the IMPACT Model. | | | | | | | | | | |
| **Task** All IMPACT participants in PPS have a designated Psychiatrist. | | | | | | | | | | |
| **Milestone #13** Measure outcomes as required in the IMPACT Model. | | | | | | | | | | |
| **Task** At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT). | | | | | | | | | | |
| **Milestone #14** Provide "stepped care" as required by the IMPACT Model. | | | | | | | | | | |
| **Task** In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm that includes evaluation of patient after 10-12 weeks after start of treatment plan. | | | | | | | | | | |
| **Milestone #15** Use EHRs or other technical platforms to track all patients engaged in this project. | | | | | | | | | | |
| **Task** EHR demonstrates integration of medical and behavioral health record within individual patient records. | | | | | | | | | | |
| **Task** PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. | | | | | | | | | | |

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Milestone #1** Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3. | | | | | | | | | | |
| **Task** All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3. | 133 | 200 | 200 | 200 | 200 | 200 | 200 | 200 | 200 | 200 |
| **Task** Behavioral health services are co-located within PCMH/APC practices and are available. | 23 | 35 | 35 | 35 | 35 | 35 | 35 | 35 | 35 | 35 |
| **Task** 1.Identify project team members from working groups and define roles and responsibilities | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task** 2. Identify a project leader/ champion to spearhead the effort and work collaboratively with the PCMH Project Manager to coordinate efforts to obtain PCMH NCQA level 3 certification | | | | | | | | | | |
| **Task** 3. Distribute a survey of interest to primary care sites in the community; identifying interest in the PCMH Collaborative Care Model. | | | | | | | | | | |
| **Task** 4. Convene interested providers and sites to review requirements and capabilities to develop a PCMH Collaborative Care Model | | | | | | | | | | |
| **Task** 5. Identify DSRIP project requirements, milestones (deliverable), and metrics and build these steps into the project team process. | | | | | | | | | | |
| **Task** 6. Assess each providers capabilities and development/resource needs to meet project requirements and milestones. | | | | | | | | | | |
| **Task** 7. Define future state of colocation of services | | | | | | | | | | |
| **Task** 8. Align plan for PCMH with project 2.a.i (Integrated Delivery System) to ensure that practices will meet NCQA standards and that the timeline for each site is appropriate across projects requiring certification | | | | | | | | | | |
| **Task** 9. Finalize strategy for achieving PCMH Level 3 certification for contracted providers at PPS level | | | | | | | | | | |
| **Task** 10. Classify providers according to criteria to their level of NCQA qualification: not recognized, Level 1, 2, and 3 using 2011 standards, and those that are in process of applying for 2014 standards. | | | | | | | | | | |
| **Task** 11. Engage providers meeting the standards to participate in the model with behavioral health providers. | | | | | | | | | | |
| **Task** 12. Use evidence-based clinical practices, program design and management approaches where they are available. | | | | | | | | | | |
| **Task** 13. Coordinate the availability and schedules of behavioral health services and providers to ensure adequate coverage within PCMH practices for the expected volume of patients and hours of service required. | | | | | | | | | | |
| **Task** 14. For all entities and potential future partner entities document | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| the level of care, scope of services, populations touched and managed, existing contractual arrangements between entities, and State/ Federal regulations related to reimbursement and contracting, existing QI processes with compensation based on outcomes and any forays into alternate payment models | | | | | | | | | | |
| **Task**<br>15. Address any legal, financial and contractual issues, regulatory policies, waivers, licensure/certifications to provide co-location of services | | | | | | | | | | |
| **Task**<br>16. Convene the project team to develop the collaborative care practices | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response:<br>17. Develop a project design for providing BH care at the PC sites. This will include the identification & placement of BH providers as well as physicial space within the PC site to perform screening and other services. Where appropriate, the model will include strategies to integrate PC and BH care through best practices such as case conferencing. | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>18. Collaborate with teh worforce team to strategize on recruitment, training, and involvement of behavioral health providers to ensure adequate services are available in the integration sites. Track & monitor workforce enhancements on a regular basis and adjust as needed to ensure success. | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>19. Report progress on all aspects of the project re-desgin, including but not limited to workforce enhancement on a quarterly basis to appropriate project leads, the Board of Managers and committees | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>20. Consider innovative programs, such as partnering with surrounding PPS's, leveraging career development programs at area learning institions, utilizing telemedicine avenues, etc...to ehance recruitment & retention of behavioral health providers that will be necessary to ensure success. | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response - Stakeholder Engagment:<br>21. While we have 35 providers committed, we have more behaviorist within the network to consider for implementation. | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Milestone #2** Develop collaborative evidence-based standards of care including medication management and care engagement process. | | | | | | | | | | |
| **Task** Regularly scheduled formal meetings are held to develop collaborative care practices. | | | | | | | | | | |
| **Task** Coordinated evidence-based care protocols are in place, including medication management and care engagement processes. | | | | | | | | | | |
| **Task** 1. Establish the project work team that includes PCMH and behavioral health physician representatives, community resources and member advisors. | | | | | | | | | | |
| **Task** 2. Incorporate the identified standards and their sources into the communication action plan for providers. | | | | | | | | | | |
| **Task** 3. Utilize nationally recognized evidence based tools to implement at co-located practices for behavioral health conditions with emphasis on behavioral health treating chronic health conditions | | | | | | | | | | |
| **Task** 4. Present recommendations to the Clinical Integration and Quality committee of the PPS on project methodology | | | | | | | | | | |
| **Task** 5. Implement processes to schedule, conduct and document scheduled formal meetings to develop collaborative care practices and ensure coordinated evidence-based care protocols are in place, including medication management and care engagement processes. | | | | | | | | | | |
| **Task** 6. Document the workflow steps including role/responsibility to screen, frequency, documentation, policies/procedures to support 100% colocation | | | | | | | | | | |
| **Task** 7. Develop the warm hand off process to the behavioral health resource and PCMH feedback process including scripting for communication. | | | | | | | | | | |
| **Task** 8. Develop means to provide educational/training through learning management system (LMS) on evidence-based tools focusing on behavioral health challenges most commonly seen in primary care | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task** 9. Develop the steps to implement tools and processes into PCMH and incorporate with care management; insert steps into the work plan. | | | | | | | | | | |
| **Task** 10. Track and evaluate programs roll out using rapid cycle team evaluation techniques | | | | | | | | | | |
| **Task** 11. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | | | | | | | | | | |
| **Milestone #3** Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs. | | | | | | | | | | |
| **Task** Policies and procedures are in place to facilitate and document completion of screenings. | | | | | | | | | | |
| **Task** Screenings are documented in Electronic Health Record. | | | | | | | | | | |
| **Task** At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT). | | | | | | | | | | |
| **Task** Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record. | 46 | 69 | 96 | 127 | 162 | 200 | 200 | 200 | 200 | 200 |
| **Task** 1. Complete assessment to determine which preventive behavioral health screenings are currently used at each PCP sites | | | | | | | | | | |
| **Task** 2. Include representatives from practices and the IT project team to identify feasibility to integrate a user friendly screening tools into EMR and practices | | | | | | | | | | |
| **Task** 3. Develop methods to document number of clients screened via alternate techniques until IT solutions in place | | | | | | | | | | |
| **Task** 4. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | | | | | | | | | | |
| **Task** 5. Outline the workflow steps including role/responsibility to screen, frequency, documentation, policies/procedures to | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| support client screening | | | | | | | | | | |
| **Task** 6. Outline the workflow steps from screening completion to include result evaluation, patient communication scripting, provider review, referral triggers, referral process and documentation | | | | | | | | | | |
| **Task** 7. Define process for handling patients that are deemed at-risk based on the screen, including behavioral health interventions | | | | | | | | | | |
| **Task** 8. Define process for documenting results in EHR for patients that are deemed at-risk based on the screening | | | | | | | | | | |
| **Task** 9. Establish the warm hand off process to the behavioral health resource and PCMH feedback process including patient scripting for communication. | | | | | | | | | | |
| **Task** 10. Implement evidence based practices for clinical screenings | | | | | | | | | | |
| **Task** 11 Track and evaluate programs roll out using rapid cycle team evaluation techniques | | | | | | | | | | |
| **Milestone #4** Use EHRs or other technical platforms to track all patients engaged in this project. | | | | | | | | | | |
| **Task** EHR demonstrates integration of medical and behavioral health record within individual patient records. | | | | | | | | | | |
| **Task** PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. | | | | | | | | | | |
| **Task** 1. Determine requirements for identification of targeted patients and tracking actively engaged patients per state-provided specifications for the DSRIP program. | | | | | | | | | | |
| **Task** 2. Review strategies and tools needed to promote DSRIP specific Patient Engagement | | | | | | | | | | |
| **Task** 3. Working with the project team document current and future state work flow in addition to capturing manual solutions in place at this time. | | | | | | | | | | |
| **Task** 4. Assess current EHR and other technical platforms in the PPS against established requirements for patient identification and | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| tracking, system notification, and treatment plan creation. | | | | | | | | | | |
| **Task** 5. Create a gap analysis based on the work flow analysis to determine incremental IT needs and associated budget, including short-term manual solutions. | | | | | | | | | | |
| **Task** 6. Identify prioritization of systems to build or associated change with separate work streams focused on implementing new Electronic Health Record Systems vs. RHIO connectivity based on the DSRIP project needs and associated providers' needs | | | | | | | | | | |
| **Task** 7. Develop a roll-out plan for systems to achieve clinical data sharing, including a training plan to support the successful implementation of new platforms and processes | | | | | | | | | | |
| **Task** 8. Establish a process for monitoring project milestones and performance | | | | | | | | | | |
| **Task** 9. Where electronic functionality is not yet ready, implement alternate in the interim and track conversion to electronic systems. | | | | | | | | | | |
| **Task** 10. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS. | | | | | | | | | | |
| **Task** 11. Develop a process for determining how success will be measured that incorporates feedback from practitioners and other key users of IT, including financial and patient engagement impact and risks. | | | | | | | | | | |
| **Milestone #5** Co-locate primary care services at behavioral health sites. | | | | | | | | | | |
| **Task** PPS has achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3. | 46 | 69 | 96 | 127 | 162 | 200 | 200 | 200 | 200 | 200 |
| **Task** Primary care services are co-located within behavioral Health practices and are available. | 46 | 69 | 96 | 127 | 162 | 200 | 200 | 200 | 200 | 200 |
| **Task** Primary care services are co-located within behavioral Health practices and are available. | 8 | 12 | 17 | 22 | 28 | 35 | 35 | 35 | 35 | 35 |
| **Task** 1. Distribute a survey of interest to behavioral service sites in the community; identify interest in the Behavioral Health Collaborative Care Model. | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task** 2. Convene interested providers and sites to review requirements and capabilities to develop a Behavioral Health Service Site model. | | | | | | | | | | |
| **Task** 3. Identify model project requirements, milestones (deliverables), and metrics and build these steps into the project team process | | | | | | | | | | |
| **Task** 4. Identify those providers that are co-located and secure legal advice to address any identified licensure issues. | | | | | | | | | | |
| **Task** 5. Assess each partner's capabilities and development/resource needs to meet project requirements and milestones. | | | | | | | | | | |
| **Task** 6. Define future state of colocation of services | | | | | | | | | | |
| **Task** 7. Use evidence-based clinical practices, program design and management approaches where they are available. | | | | | | | | | | |
| **Task** 8. Align plan for PCMH with project 2.a.i (Integrated Delivery System) to ensure that practices will meet NCQA standards and that the timeline for each site is appropriate across projects requiring certification | | | | | | | | | | |
| **Task** 9. Convene community, facility and PPS governance representatives to review PPS program structure, MOUs, financial plan and regulatory requirements for the Behavioral Health Site model structure | | | | | | | | | | |
| **Task** 10. Engage providers meeting the standards to participate in the model with behavioral health providers | | | | | | | | | | |
| **Task** 11. Develop support and training modules for collaboration of providers and integration of roles | | | | | | | | | | |
| **Task** 12. Classify providers according to criteria to their level of NCQA qualification: not recognized, Level 1, 2, and 3 using 2011 standards, and those that are in process of applying for 2014 standards. | | | | | | | | | | |
| **Task** 13. Engage providers meeting the standards to participate in the model with PCP and PCMH providers | | | | | | | | | | |
| **Task** 14. Coordinate the availability and schedules of behavioral health services and providers to ensure adequate coverage within | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| PCMH practices for the expected volume of patients and hours of service required. | | | | | | | | | | |
| **Task**<br>15. For all entities and potential future partner entities document the level of care, scope of services, populations touched and managed, existing contractual arrangements between entities, and State/ Federal regulations related to reimbursement and contracting, existing QI processes with compensation based on outcomes and any forays into alternate payment models | | | | | | | | | | |
| **Task**<br>16. Address any legal, financial and contractual issues, regulatory policies, waivers, licensure/certifications to provide co-location of services | | | | | | | | | | |
| **Task**<br>17. Convene the project team to develop the collaborative care practices | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response:<br>18. Develop an overall program design & approach (including generic work flow) to provide primary care within the BH settting in an integrated manner. | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response:<br>19. Strategize with the Clinical LeadershipCouncil, Clinical Integration Conmmittee, CBO's and other relevant stakeholders to collaborate and include internal and external stakeholders in leveraging BH and SUD providers to particpate in co-location. | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response:<br>20. Develop timeline for workforce recrutiment strategy. Incorporate CBOs as key stakeholders in model development and execution. | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>21. Assess current state BH & SUD provider sites to identify opportunities to co-locate care and services using the Collaborative Care Model | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>22. Identify primary care providers through stakeholder engagemnt that will particpate in screening and referral processes for BH and SUD referrals. Refer to lead health homes for additional BH care managment support and verify capacity of health homesis sufficient to handle all referrals. | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>9-24-15 Remediation Response<br>23. Evaluate success of the program based on achievement of Domain 1 metrics and improved outcomes. Develop and produce quarterly outcomes dashboards for project teams, CIQC and Goverance committees to track program success and respond to opportunites for improvment when appropriate. | | | | | | | | | | |
| **Milestone #6**<br>Develop collaborative evidence-based standards of care including medication management and care engagement process. | | | | | | | | | | |
| **Task**<br>Regularly scheduled formal meetings are held to develop collaborative care practices. | | | | | | | | | | |
| **Task**<br>Coordinated evidence-based care protocols are in place, including a medication management and care engagement process. | | | | | | | | | | |
| **Task**<br>1. Establish the project work team that includes PCMH and behavioral health physician representatives, community resources and member advisors. | | | | | | | | | | |
| **Task**<br>2. Incorporate the identified standards and their sources into the communication action plan for providers | | | | | | | | | | |
| **Task**<br>3. Utilize nationally recognized evidence based tools to implement at co-located practices for primary care, preventative conditions and chronic health conditions. | | | | | | | | | | |
| **Task**<br>4. Present recommendations to the Clinical Integration and Quality committee of the PPS on project methodology | | | | | | | | | | |
| **Task**<br>5. Implement processes to schedule, conduct and document scheduled formal meetings to develop collaborative care practices and ensure coordinated evidence-based care protocols are in place, including medication management and care engagement processes. | | | | | | | | | | |
| **Task**<br>6. Document the workflow steps including role/responsibility to screen, frequency, documentation, policies/procedures to support 100% colocation | | | | | | | | | | |
| **Task**<br>7. Develop the warm hand off process to the PCP resource and behavioral health feedback process including scripting for | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| communication | | | | | | | | | | |
| **Task** 8. Develop means to provide educational/training through learning management system (LMS) on evidence-based tools focusing on behavioral health challenges most commonly seen in behavioral health | | | | | | | | | | |
| **Task** 9. Develop the steps to implement tools and processes into behavioral health services and incorporate with care management; insert steps into the work plan. | | | | | | | | | | |
| **Task** 10. Track and evaluate programs roll out using rapid cycle team evaluation techniques | | | | | | | | | | |
| **Task** 11. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | | | | | | | | | | |
| **Milestone #7** Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs. | | | | | | | | | | |
| **Task** Screenings are conducted for all patients. Process workflows and operational protocols are in place to implement and document screenings. | | | | | | | | | | |
| **Task** Screenings are documented in Electronic Health Record. | | | | | | | | | | |
| **Task** At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT). | | | | | | | | | | |
| **Task** Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record. | 46 | 69 | 96 | 127 | 162 | 200 | 200 | 200 | 200 | 200 |
| **Task** 1. Complete assessment to determine which preventive behavioral health screenings are currently used at each behavioral health services sites | | | | | | | | | | |
| **Task** 2. Include representatives from practices and the IT project team to identify a user friendly approach to integrate screening tools into EMR and practices | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>3. Outline the workflow steps including role/responsibility to screen, frequency, documentation, policies/procedures to support client screening | | | | | | | | | | |
| **Task**<br>4. Outline the workflow steps from screening completion to include result evaluation, patient communication scripting, provider review, referral triggers, referral process and documentation | | | | | | | | | | |
| **Task**<br>5. Define process for handling patients that are deemed at-risk based on the screen, including behavioral health interventions | | | | | | | | | | |
| **Task**<br>6. Define process for documenting results in EHR for patients that are deemed at-risk based on the screening | | | | | | | | | | |
| **Task**<br>7. Establish the warm hand off process to the PCP resource and behavioral health feedback process including patient scripting for communication | | | | | | | | | | |
| **Task**<br>8. Implement evidence based screenings and brief intervention processes | | | | | | | | | | |
| **Task**<br>9. Track and evaluate programs roll out using rapid cycle team evaluation techniques | | | | | | | | | | |
| **Task**<br>10. Develop methods to document number of clients screened via alternate techniques until IT solutions in place | | | | | | | | | | |
| **Task**<br>11. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | | | | | | | | | | |
| **Milestone #8**<br>Use EHRs or other technical platforms to track all patients engaged in this project. | | | | | | | | | | |
| **Task**<br>EHR demonstrates integration of medical and behavioral health record within individual patient records. | | | | | | | | | | |
| **Task**<br>PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. | | | | | | | | | | |
| **Task**<br>1. Determine requirements for identification of targeted patients and tracking actively engaged patients per state-provided specifications for the DSRIP program. | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>2. Review strategies and tools needed to promote DSRIP specific Patient Engagement | | | | | | | | | | |
| **Task**<br>3. Working with the project team document current and future state work flow in addition to capturing manual solutions in place at this time. | | | | | | | | | | |
| **Task**<br>4. Assess current EHR and other technical platforms in the PPS against established requirements for patient identification and tracking, system notification, and treatment plan creation. | | | | | | | | | | |
| **Task**<br>5. Create a gap analysis based on the work flow analysis to determine incremental IT needs and associated budget, including short-term manual solutions. | | | | | | | | | | |
| **Task**<br>6. Identify prioritization of systems to build or associated change with separate work streams focused on implementing new Electronic Health Record Systems vs. RHIO connectivity based on the DSRIP project needs and associated providers' needs | | | | | | | | | | |
| **Task**<br>7. Develop a roll-out plan for systems to achieve clinical data sharing, including a training plan to support the successful implementation of new platforms and processes | | | | | | | | | | |
| **Task**<br>8. Establish a process for monitoring project milestones and performance. | | | | | | | | | | |
| **Task**<br>9. Where electronic functionality is not yet ready, implement alternate in the interim and track conversion to electronic systems. | | | | | | | | | | |
| **Task**<br>10. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS. | | | | | | | | | | |
| **Task**<br>11. Develop a process for determining how success will be measured that incorporates feedback from practitioners and other key users of IT, including financial and patient engagement impact and risks. | | | | | | | | | | |
| **Milestone #9**<br>Implement IMPACT Model at Primary Care Sites. | | | | | | | | | | |
| **Task**<br>PPS has implemented IMPACT Model at Primary Care Sites. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Milestone #10**<br>Utilize IMPACT Model collaborative care standards, including | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| developing coordinated evidence-based care standards and policies and procedures for care engagement. | | | | | | | | | | |
| **Task**<br>Coordinated evidence-based care protocols are in place, including a medication management and care engagement process to facilitate collaboration between primary care physician and care manager. | | | | | | | | | | |
| **Task**<br>Policies and procedures include process for consulting with Psychiatrist. | | | | | | | | | | |
| **Milestone #11**<br>Employ a trained Depression Care Manager meeting requirements of the IMPACT model. | | | | | | | | | | |
| **Task**<br>PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records. | | | | | | | | | | |
| **Task**<br>Depression care manager meets requirements of IMPACT model, including coaching patients in behavioral activation, offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan. | | | | | | | | | | |
| **Milestone #12**<br>Designate a Psychiatrist meeting requirements of the IMPACT Model. | | | | | | | | | | |
| **Task**<br>All IMPACT participants in PPS have a designated Psychiatrist. | | | | | | | | | | |
| **Milestone #13**<br>Measure outcomes as required in the IMPACT Model. | | | | | | | | | | |
| **Task**<br>At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT). | | | | | | | | | | |
| **Milestone #14**<br>Provide "stepped care" as required by the IMPACT Model. | | | | | | | | | | |
| **Task**<br>In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm that includes evaluation of patient after 10-12 weeks after start of treatment plan. | | | | | | | | | | |
| **Milestone #15**<br>Use EHRs or other technical platforms to track all patients engaged in this project. | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task** EHR demonstrates integration of medical and behavioral health record within individual patient records. | | | | | | | | | | |
| **Task** PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. | | | | | | | | | | |

### Prescribed Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|

No Records Found

### Prescribed Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|
| Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3. | Tasks 4, 5, 6, and 7 originally dated 12/31/2015 have been moved to 6/30/2016 to reflect the ongoing nature of the work. |
| Develop collaborative evidence-based standards of care including medication management and care engagement process. | Tasks 1 and 2 originally dated 12/31/2015 have been moved to 6/30/2016 to reflect the ongoing nature of the work. |
| Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs. | |
| Use EHRs or other technical platforms to track all patients engaged in this project. | |
| Co-locate primary care services at behavioral health sites. | Task 4 originally dated 12/31/2015 has been moved to 3/31/2016. Tasks 2, 3, 5, and 6 originally dated 12/31/2015 have been moved to 6/30/2016. These changes reflect the ongoing nature of the work. |
| Develop collaborative evidence-based standards of care including medication management and care engagement process. | Tasks 1 and 2 originally dated 12/31/2015 have been moved to 6/30/2016 to reflect the ongoing nature of the work. |
| Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs. | |
| Use EHRs or other technical platforms to track all patients engaged in this project. | |
| Implement IMPACT Model at Primary Care Sites. | |
| Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Prescribed Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|
| policies and procedures for care engagement. | |
| Employ a trained Depression Care Manager meeting requirements of the IMPACT model. | |
| Designate a Psychiatrist meeting requirements of the IMPACT Model. | |
| Measure outcomes as required in the IMPACT Model. | |
| Provide "stepped care" as required by the IMPACT Model. | |
| Use EHRs or other technical platforms to track all patients engaged in this project. | |

### Milestone Review Status

| Milestone # | Review Status | IA Formal Comments |
|---|---|---|
| **Milestone #1** | Pass & Ongoing | |
| **Milestone #2** | Pass & Ongoing | |
| **Milestone #3** | Pass & Ongoing | |
| **Milestone #4** | Pass & Ongoing | |
| **Milestone #5** | Pass & Ongoing | |
| **Milestone #6** | Pass & Ongoing | |
| **Milestone #7** | Pass & Ongoing | |
| **Milestone #8** | Pass & Ongoing | |
| **Milestone #9** | Pass & Ongoing | |
| **Milestone #10** | Pass & Ongoing | |
| **Milestone #11** | Pass & Ongoing | |
| **Milestone #12** | Pass & Ongoing | |
| **Milestone #13** | Pass & Ongoing | |
| **Milestone #14** | Pass & Ongoing | |
| **Milestone #15** | Pass & Ongoing | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 3.a.i.4 - PPS Defined Milestones

**Instructions :**

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for PPS-defined milestones.

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|

No Records Found

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC  (PPS ID:3)

### IPQR Module 3.a.i.5 - IA Monitoring

**Instructions :**

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Project 3.a.iv – Development of Withdrawal Management (e.g., ambulatory detoxification, ancillary withdrawal services) capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs

#### IPQR Module 3.a.iv.1 - Major Risks to Implementation and Mitigation Strategies

**Instructions :**

Please describe what the major risks are for this project, as well as the actions you plan to take to mitigate them.

The AFBHC PPS recognizes that the 2012 CNA demonstrated a 15% increase in the numbers of patients presenting in the emergency departments for opiate and other drug related withdrawal issues. An identified risk to the development of withdrawal management services is the existing shortage of behavioral health providers in the area, particularly those DEA-X licensed physicians. This project may exacerbate the existing shortage of practicing X license physicians and behavioral health clinicians in general. This shortage in the PPS area has led to an imbalance of implementation support between medically-related projects and behavioral-health related projects. Mitigation strategy to address this risk is to build ambulatory detoxification centers within the community based treatment programs and to build on these programs once established. Initially five areas will be targeted for building services. The PPS with the help of behavioral health leads will identify a project medical director as a champion experienced with ambulatory detoxification to educate and motivate peers in provide practices and other settings to encourage participation in services. Success to the development of ambulatory withdrawal management will be measured by a decrease in volume of this patient population using local emergency rooms for services and an increase in use of ambulatory detox centers demonstrated with a quarterly review of project metrics and outcomes.

There are multiple IT Risks, such as data interoperability dependent upon working with multiple vendors that may not support existing standards- the risk mitigation strategy is to engage vendors early & determine supplemental solutions where available. The RHIO, which is expected to be the interoperable clinical platform, has expressed limitations on data sharing per NY state policies, working with EHR vendors to achieve data sharing & balancing the needs of DSRIP with their existing commitments. As Population Health IT (PHIT) systems and tools are required, any delay to PHIT implementation delays the projects & risks not meeting speed & scale requirements. PHIT rollout depends on sufficient capital funding from NY state & delay in the capital release will delay the rollout. The PPS will work closely with the RHIO, accelerate implementation of PHIT interoperability & tools, use alternate methods where EHRs & PHIT tool functionality aren't yet ready & work with NY to ensure capital is provided in sufficient time.

Another risk identified is the potential for an imbalance of implementation support between medically-related projects and behavioral-health related projects. The strategy to manage this risk will be to identify project leads for behavioral health projects as part of the Clinical Integration and Quality Committee to ensure behavioral health expectations are coordinated and integrated with other primary care project requirements. Representation of a project lead for the behavioral health projects will assist in supporting culture change to holistic patient approach. Culturally sensitive education sessions will be developed in conjunction with the clinical integration and workforce workstreams and provided to the engaged providers throughout the PPS, including but not limited to community based organizations, hospitals, primary care and non-primary care physicians. Session attendance will be tracked and number of participants will be reported quarterly to demonstrate increased awareness and sensitivity to withdrawal management patient and care protocols.

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 3.a.iv.2 - Patient Engagement Speed

**Instructions :**

Enter the number of patients actively engaged through the current quarter. The number entered into the "Patient Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for DY1 Q3 should include patients previously reported in DY1 Q2 plus new patients engaged in DY1 Q3. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

| Benchmarks | |
|---|---|
| **100% Actively Engaged By** | **Expected Patient Engagement** |
| DY4,Q4 | 3,949 |

| Patients Engaged to Date in Current DY | DY1,Q3 Patient Update | % of Semi-Annual Commitment To-Date | Semi-Annual Variance of Projected to Actual | % of Total Actively Engaged Patients To-Date |
|---|---|---|---|---|
| 0 | 0 | 0.00% | 1,019 | 0.00% |

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (1,019)

### Current File Uploads

| User ID | File Type | File Name | File Description | Upload Date |
|---|---|---|---|---|
| cdomeier | Communication Documentation | 3_PMDL4015_1_3_20160129160721_DY1Q3_absense_of_patient_registry_explanation.docx | Explanation for absence of DY1, Q3 Patient Update | 01/29/2016 04:07 PM |

**Narrative Text :**

For PPS to provide additional context regarding progress and/or updates to IA.

### Module Review Status

| Review Status | IA Formal Comments |
|---|---|
| Fail | The PPS failed to meet at least 80% of its actively engaged commitments for DY1Q3. The documentation does not support the reported actively engaged numbers. |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 3.a.iv.3 - Prescribed Milestones

**Instructions :**

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for prescribed milestones. For milestones that are due and completed within the reporting period, documentation is required to provide evidence of project requirement achievement. Any explanations regarding altered or missed provider commitments should be included within the narrative box, not as text within uploaded documentation.

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| **Milestone #1** Develop community-based addiction treatment programs that include outpatient SUD sites with PCP integrated teams, and stabilization services including social services. | Project | N/A | In Progress | 04/01/2015 | 09/30/2017 | 04/01/2015 | 09/30/2017 | 09/30/2017 | DY3 Q2 |
| **Task** PPS has developed community-based addiction treatment programs that include outpatient SUD sites, PCP integrated teams, and stabilization services. | Project | | In Progress | 04/01/2015 | 09/30/2017 | 04/01/2015 | 09/30/2017 | 09/30/2017 | DY3 Q2 |
| **Task** 1. Identify project lead at PPS level | Project | | Completed | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 |
| **Task** 2. Form project teams, including behavorial service providers, residential providers, hospitals, outpatient service providers, withdrawal management service representatives, administrative and front line staff and PPS representatives | Project | | Completed | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 |
| **Task** 3. Confirm provider and/or sites for community-based addictions services program (St. Peter's Health Partners, St. Mary's Troy, St. Mary's Outpatient-Amsterdam, SPARC Cohoes, SPARC Central Ave, SPARC Guilderland Equinox, Belvedere, Conifer Glenville & Conifer Troy) | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 4. Assess current state withdrawal management services, including outpatient SUD sites with PCP integrated teams capabilities | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 5. Consider an assessment of clinical, recovery and peer support service provider staff and resources that would be required to implement the project | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task** 6. Recognize any geographical gap in services within community | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| based programs | | | | | | | | | |
| **Task** 7. Include key partners in project planning including OASAS, social service providers, criminal justice, public health, health centers, urgent care centers, intervention hotlines, housing representatives and other representatives | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 8. Project team to make recommendations PPS to confirmed sites for community-based addiction treatment (refer to # 3 above) | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 9. PPS has requested licensure or waivers necessary to perform withdrawal management services | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 10. PPS has referral and care coordination agreements in place with providers and community partners within the PPS | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 11. Align program with OASAS levels of care | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 12. Determine hours of operation that will minimize gaps in services | Project | | In Progress | 04/01/2015 | 09/30/2016 | 04/01/2015 | 09/30/2016 | 09/30/2016 | DY2 Q2 |
| **Task** 13. Define future state of the withdrawal management program and develop plans to address gaps in services if identified | Project | | In Progress | 04/01/2015 | 09/30/2016 | 04/01/2015 | 09/30/2016 | 09/30/2016 | DY2 Q2 |
| **Task** 14. Coordinate with other projects within the PPS, such as the ED Care Triage project, integration of primary care and behavioral health services and PCMH requirements | Project | | In Progress | 04/01/2015 | 09/30/2017 | 04/01/2015 | 09/30/2017 | 09/30/2017 | DY3 Q2 |
| **Task** 15. Implement clinical guidelines and processes to provide stabilization services | Project | | In Progress | 04/01/2015 | 09/30/2017 | 04/01/2015 | 09/30/2017 | 09/30/2017 | DY3 Q2 |
| **Task** 16. Coordinate with PCP practice based withdrawal management and maintenance clinical pathways and care models | Project | | In Progress | 04/01/2015 | 09/30/2017 | 04/01/2015 | 09/30/2017 | 09/30/2017 | DY3 Q2 |
| **Task** 17. Track and evaluate programs at each site using rapid cycle evaluation techniques | Project | | In Progress | 04/01/2015 | 09/30/2017 | 04/01/2015 | 09/30/2017 | 09/30/2017 | DY3 Q2 |
| **Task** | Project | | In Progress | 04/01/2015 | 09/30/2017 | 04/01/2015 | 09/30/2017 | 09/30/2017 | DY3 Q2 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| 18. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | | | | | | | | | |
| **Milestone #2** Establish referral relationships between community treatment programs and inpatient detoxification services with development of referral protocols. | Project | N/A | In Progress | 04/01/2015 | 09/30/2017 | 04/01/2015 | 09/30/2017 | 09/30/2017 | DY3 Q2 |
| **Task** PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients. | Provider | Hospital | In Progress | 04/01/2015 | 09/30/2017 | 04/01/2015 | 09/30/2017 | 09/30/2017 | DY3 Q2 |
| **Task** PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients. | Provider | Mental Health | In Progress | 04/01/2015 | 09/30/2017 | 04/01/2015 | 09/30/2017 | 09/30/2017 | DY3 Q2 |
| **Task** PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients. | Provider | Substance Abuse | In Progress | 04/01/2015 | 09/30/2017 | 04/01/2015 | 09/30/2017 | 09/30/2017 | DY3 Q2 |
| **Task** Regularly scheduled formal meetings are held to develop collaborative care practices among community treatment programs as well as between community treatment programs and inpatient detoxification facilities. | Project | | In Progress | 04/01/2015 | 09/30/2017 | 04/01/2015 | 09/30/2017 | 09/30/2017 | DY3 Q2 |
| **Task** Coordinated evidence-based care protocols are in place for community withdrawal management services. Protocols include referral procedures. | Project | | In Progress | 04/01/2015 | 09/30/2017 | 04/01/2015 | 09/30/2017 | 09/30/2017 | DY3 Q2 |
| **Task** 1. Identify current state inpatient detoxification services and community treatment program stakeholders | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 2. Establish referral relationships with a focus on withdrawal management practice capacity | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 3. Initiate and conduct regularly scheduled meetings with relevant agendas for identified stakeholders and representatives | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| to develop and recommend evidence based practice models | | | | | | | | | |
| **Task** 4. Collaborate with other project groups within the PPS project to strengthen engagement and representation with key stakeholders, providers and patients with emphasis on behavioral focused projects to raise their awareness that the outpatient detox centers exist and can see their patients. | Project | | In Progress | 04/01/2015 | 09/30/2017 | 04/01/2015 | 09/30/2017 | 09/30/2017 | DY3 Q2 |
| **Task** 5. Adopt evidence based clinical and care pathways that include referral protocols to develop and strengthen collaborative care practices within the PPS. Submit approved pathways and referral process to the Clinical Integration & Quality committee for review. | Project | | In Progress | 04/01/2016 | 09/30/2017 | 04/01/2016 | 09/30/2017 | 09/30/2017 | DY3 Q2 |
| **Task** 6. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | Project | | In Progress | 04/01/2016 | 09/30/2017 | 04/01/2016 | 09/30/2017 | 09/30/2017 | DY3 Q2 |
| **Task** 7. Implement adopted and approved clinical guidelines and referral processes to identified sites and to participating providers | Project | | In Progress | 04/01/2016 | 09/30/2017 | 04/01/2016 | 09/30/2017 | 09/30/2017 | DY3 Q2 |
| **Task** 8. Project team to make recommendations to the project medical director and Clinical Integration and Quality committee on best methods to track outcomes and indicators to measure effectiveness of withdrawal management processes | Project | | In Progress | 04/01/2016 | 09/30/2017 | 04/01/2016 | 09/30/2017 | 09/30/2017 | DY3 Q2 |
| **Milestone #3** Include a project medical director, board certified in addiction medicine, with training and privileges for use of buprenorphine and buprenorphine/naltrexone as well as familiarity with other withdrawal management agents. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** PPS has designated at least one qualified and certified physician with training and privileges for use of buprenorphine/Naltrexone and other withdrawal agents. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 1. Develop a functional job description, with compensation and benefits methodology that links to workforce committee, who is board certified in addiction medicine, with training and privileges | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 09/30/2016 | 09/30/2016 | DY2 Q2 |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| for use of buprenorphine and buprenorphine/naltrexone and other treatment modalities | | | | | | | | | |
| **Task** 2. Recruit from existing network of stakeholders a project medical director as defined. Coordinate efforts with workforce strategies to widen search outside PPS provider network as necessary to recruit ideal candidate. | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2016 | 12/31/2016 | DY2 Q3 |
| **Task** 3. Designate and retain contractually project medical director | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 4. Participate with PPS as project liaison between PPS, project team and other projects within the organization | Project | | In Progress | 09/01/2015 | 03/31/2016 | 09/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 5. Develop communication pathways for project medical director to guide project development, measure and report outcomes and initiate change if required. | Project | | In Progress | 09/01/2015 | 03/31/2016 | 09/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Milestone #4** Identify and link to providers approved for outpatient medication management of opioid addiction who agree to provide continued maintenance therapy and collaborate with the treatment program and care manager. These may include practices with collocated behavioral health services, opioid treatment programs or outpatient SUD clinics. | Project | N/A | In Progress | 04/01/2015 | 09/30/2017 | 04/01/2015 | 09/30/2017 | 09/30/2017 | DY3 Q2 |
| **Task** PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients. | Provider | Practitioner - Primary Care Provider (PCP) | In Progress | 04/01/2015 | 09/30/2017 | 04/01/2015 | 09/30/2017 | 09/30/2017 | DY3 Q2 |
| **Task** PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients. | Provider | Practitioner - Non-Primary Care Provider (PCP) | In Progress | 04/01/2015 | 09/30/2017 | 04/01/2015 | 09/30/2017 | 09/30/2017 | DY3 Q2 |
| **Task** PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients. | Provider | Hospital | In Progress | 04/01/2015 | 09/30/2017 | 04/01/2015 | 09/30/2017 | 09/30/2017 | DY3 Q2 |

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

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## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| **Task** PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients. | Provider | Mental Health | In Progress | 04/01/2015 | 09/30/2017 | 04/01/2015 | 09/30/2017 | 09/30/2017 | DY3 Q2 |
| **Task** PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients. | Provider | Substance Abuse | In Progress | 04/01/2015 | 09/30/2017 | 04/01/2015 | 09/30/2017 | 09/30/2017 | DY3 Q2 |
| **Task** 1. Project team and Medical Director to collaborate with identification of stakeholders and form task force to link to providers for outpatient withdrawal management services | Project | | In Progress | 04/01/2015 | 09/30/2016 | 04/01/2015 | 09/30/2016 | 09/30/2016 | DY2 Q2 |
| **Task** 2. Complete current state assessment of participating providers and programs and to determine current services and current clinical state | Project | | In Progress | 04/01/2015 | 09/30/2016 | 04/01/2015 | 09/30/2016 | 09/30/2016 | DY2 Q2 |
| **Task** 3. Link to evidence based approved protocols for triage, assessments, determination of appropriateness of care and referrals | Project | | In Progress | 04/01/2015 | 09/30/2016 | 04/01/2015 | 09/30/2016 | 09/30/2016 | DY2 Q2 |
| **Task** 4. Establish relationships with identified providers and programs, review participating list and modify as necessary to reflect available resources | Project | | In Progress | 04/01/2015 | 09/30/2017 | 04/01/2015 | 09/30/2017 | 09/30/2017 | DY3 Q2 |
| **Task** 5. Integrate protocols and pathways with related projects, specifically co-location of behavioral health services, ED Care triage and other projects within the PPS to establish collaboration and integrate protocols/criteria of project | Project | | In Progress | 04/01/2015 | 09/30/2017 | 04/01/2015 | 09/30/2017 | 09/30/2017 | DY3 Q2 |
| **Milestone #5** Develop community-based withdrawal management (ambulatory detoxification) protocols based upon evidence based best practices and staff training. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** Coordinated evidence-based care protocols are in place for community withdrawal management services. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| Staff are trained on community-based withdrawal management protocols and care coordination procedures. | | | | | | | | | |
| **Task** 1. Identify sites and practitioners that will participate in community withdrawal management services | Project | | In Progress | 04/01/2015 | 12/31/2015 | 10/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 2. Convene project team with guidance from project medical director to review, select and apply protocols to designated programs | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 3. Develop project work flow for triage, assessment, and determination of appropriate level of care | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 4. Project team and project medical director to make recommendations to workforce committee regarding workforce and training needs specific to the delivery of ambulatory withdrawal management, including care coordination and connection to treatment programs | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 5. Explore opportunities to provide clients with 24 hour access to services; either through hotline or other forms of communication | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 6. Explore transportation services in area to bolster transitions between levels of care and from community to program sites and develop transportation plan | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 7. Adapt evidence based protocols for withdrawal management as necessary to support provider engagement | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 8. Develop staff training protocols for care coordination that includes ability to address detox from alcohol, opiates, and sedatives, differentiation between withdrawal management agents, assessment and evaluation of behavioral health needs, and referral processes | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 9. Develop staff training modules that reflect that training reflects co-occurring issues | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 10. Offer and track training opportunities through a learning | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| management system (LMS) to include cultural aspects of care and health literacy issues focusing on withdrawal management, substance abuse & behavioral health. | | | | | | | | | |
| **Milestone #6** Develop care management services within the SUD treatment program. | Project | N/A | In Progress | 04/01/2015 | 09/30/2017 | 04/01/2015 | 09/30/2017 | 09/30/2017 | DY3 Q2 |
| **Task** Coordinated evidence-based care protocols are in place for care management services within SUD treatment program. | Project | | In Progress | 04/01/2015 | 09/30/2017 | 04/01/2015 | 09/30/2017 | 09/30/2017 | DY3 Q2 |
| **Task** Staff are trained to provide care management services within SUD treatment program. | Project | | In Progress | 04/01/2015 | 09/30/2017 | 04/01/2015 | 09/30/2017 | 09/30/2017 | DY3 Q2 |
| **Task** 1. Identify appropriate current state provider(s) for care management services within the SUD treatment programs | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 2. Convene care management providers to establish linkages to treatment and stepped levels of care for care coordination and treatment to facilitate engagement | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 3. Adapt existing evidence-based protocols for withdrawal management to support care coordination and connection to treatment | Project | | In Progress | 04/01/2015 | 09/30/2017 | 04/01/2015 | 09/30/2017 | 09/30/2017 | DY3 Q2 |
| **Task** 4. Recommend care management service protocols through Clinical Integration committee of PPS, to coordinate with providers, outpatient services, Health homes and behavioral health support services as necessary | Project | | In Progress | 04/01/2015 | 09/30/2017 | 04/01/2015 | 09/30/2017 | 09/30/2017 | DY3 Q2 |
| **Task** 5. Identify community support resources, including transportation, child care, housing and employment training to care managers to use as resources | Project | | In Progress | 04/01/2015 | 09/30/2017 | 04/01/2015 | 09/30/2017 | 09/30/2017 | DY3 Q2 |
| **Task** 6. Offer and track training and education opportunities through a learning management system to include cultural aspects of care and health literacy issues focusing on withdrawal management | Project | | In Progress | 04/01/2016 | 09/30/2017 | 04/01/2016 | 09/30/2017 | 09/30/2017 | DY3 Q2 |
| **Task** 7. Project subcommittee and project medical director to make recommendations to Clinical Integration and Quality committees | Project | | In Progress | 04/01/2016 | 09/30/2017 | 04/01/2016 | 09/30/2017 | 09/30/2017 | DY3 Q2 |

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| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| of PPS best methods to track outcomes and revise as necessary | | | | | | | | | |
| **Milestone #7** Form agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project. | Project | N/A | In Progress | 04/01/2015 | 09/30/2017 | 04/01/2015 | 09/30/2017 | 09/30/2017 | DY3 Q2 |
| **Task** PPS has engaged MCO to develop protocols for coordination of services under this project. | Project | | In Progress | 04/01/2015 | 09/30/2017 | 04/01/2015 | 09/30/2017 | 09/30/2017 | DY3 Q2 |
| **Task** 1. Review the ambulatory detoxification program and protocols with MCO's in the region and review benefit designs and options for payment for ambulatory detox services. | Project | | In Progress | 04/01/2015 | 09/30/2016 | 04/01/2015 | 09/30/2016 | 09/30/2016 | DY2 Q2 |
| **Task** 2. Review prior authorization processes for withdrawal services and clarify member eligibility criteria for services. | Project | | In Progress | 04/01/2015 | 09/30/2016 | 04/01/2015 | 09/30/2016 | 09/30/2016 | DY2 Q2 |
| **Task** 3. Develop benefit coverage design with MCO's | Project | | In Progress | 04/01/2015 | 09/30/2016 | 04/01/2015 | 09/30/2016 | 09/30/2016 | DY2 Q2 |
| **Task** 4. Identify any issues that need to be raised with DOH for policy changes. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 5. Develop contracting strategy on behalf of the PPS and its partners relative to this project. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #8** Use EHRs or other technical platforms to track all patients engaged in this project. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 1. Determine requirements for identification of targeted patients and tracking actively engaged patients per state-provided specifications for the DSRIP program. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 2. Review strategies and tools needed to promote DSRIP specific Patient Engagement | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 3. Working with the project team document current and future state work flow in addition to capturing manual solutions in place | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| at this time. | | | | | | | | | |
| **Task** 4. Assess current EHR and other technical platforms in the PPS against established requirements for patient identification and tracking, system notification, and treatment plan creation. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 5. Create a gap analysis based on the work flow analysis to determine incremental IT needs and associated budget, including short-term manual solutions. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 6. Identify prioritization of systems to build or associated change with separate work streams focused on implementing new Electronic Health Record Systems vs. RHIO connectivity based on the DSRIP project needs and associated providers' needs | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 7. Develop a roll-out plan for systems to achieve clinical data sharing, including a training plan to support the successful implementation of new platforms and processes | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 8. Establish a process for monitoring project milestones and performance. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 9. Where electronic functionality is not yet ready, implement alternate in the interim and track conversion to electronic systems. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 10. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 11. Develop a process for determining how success will be measured that incorporates feedback from practitioners and other key users of IT, including financial and patient engagement impact and risks. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Milestone #1** Develop community-based addiction treatment programs that | | | | | | | | | | |

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# Delivery System Reform Incentive Payment Project

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## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| include outpatient SUD sites with PCP integrated teams, and stabilization services including social services. | | | | | | | | | | |
| **Task** PPS has developed community-based addiction treatment programs that include outpatient SUD sites, PCP integrated teams, and stabilization services. | | | | | | | | | | |
| **Task** 1. Identify project lead at PPS level | | | | | | | | | | |
| **Task** 2. Form project teams, including behavorial service providers, residential providers, hospitals, outpatient service providers, withdrawal management service representatives, administrative and front line staff and PPS representatives | | | | | | | | | | |
| **Task** 3. Confirm provider and/or sites for community-based addictions services program (St. Peter's Health Partners, St. Mary's Troy, St. Mary's Outpatient-Amsterdam, SPARC Cohoes, SPARC Central Ave, SPARC Guilderland Equinox, Belvedere, Conifer Glenville & Conifer Troy) | | | | | | | | | | |
| **Task** 4. Assess current state withdrawal management services, including outpatient SUD sites with PCP integrated teams capabilities | | | | | | | | | | |
| **Task** 5. Consider an assessment of clinical, recovery and peer support service provider staff and resources that would be required to implement the project | | | | | | | | | | |
| **Task** 6. Recognize any geographical gap in services within community based programs | | | | | | | | | | |
| **Task** 7. Include key partners in project planning including OASAS, social service providers, criminal justice, public health, health centers, urgent care centers, intervention hotlines, housing representatives and other representatives | | | | | | | | | | |
| **Task** 8. Project team to make recommendations PPS to confirmed sites for community-based addiction treatment (refer to # 3 above) | | | | | | | | | | |
| **Task** 9. PPS has requested licensure or waivers necessary to perform withdrawal management services | | | | | | | | | | |
| **Task** 10. PPS has referral and care coordination agreements in place with providers and community partners within the PPS | | | | | | | | | | |

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## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task** 11. Align program with OASAS levels of care | | | | | | | | | | |
| **Task** 12. Determine hours of operation that will minimize gaps in services | | | | | | | | | | |
| **Task** 13. Define future state of the withdrawal management program and develop plans to address gaps in services if identified | | | | | | | | | | |
| **Task** 14. Coordinate with other projects within the PPS, such as the ED Care Triage project, integration of primary care and behavioral health services and PCMH requirements | | | | | | | | | | |
| **Task** 15. Implement clinical guidelines and processes to provide stabilization services | | | | | | | | | | |
| **Task** 16. Coordinate with PCP practice based withdrawal management and maintenance clinical pathways and care models | | | | | | | | | | |
| **Task** 17. Track and evaluate programs at each site using rapid cycle evaluation techniques | | | | | | | | | | |
| **Task** 18. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | | | | | | | | | | |
| **Milestone #2** Establish referral relationships between community treatment programs and inpatient detoxification services with development of referral protocols. | | | | | | | | | | |
| **Task** PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients. | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 6 | 9 | 13 |
| **Task** PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients. | 0 | 0 | 0 | 0 | 0 | 0 | 27 | 45 | 68 | 95 |
| **Task** PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients. | 0 | 0 | 0 | 0 | 0 | 0 | 5 | 9 | 13 | 18 |
| **Task** Regularly scheduled formal meetings are held to develop | | | | | | | | | | |

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| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| collaborative care practices among community treatment programs as well as between community treatment programs and inpatient detoxification facilities. | | | | | | | | | | |
| **Task** Coordinated evidence-based care protocols are in place for community withdrawal management services. Protocols include referral procedures. | | | | | | | | | | |
| **Task** 1. Identify current state inpatient detoxification services and community treatment program stakeholders | | | | | | | | | | |
| **Task** 2. Establish referral relationships with a focus on withdrawal management practice capacity | | | | | | | | | | |
| **Task** 3. Initiate and conduct regularly scheduled meetings with relevant agendas for identified stakeholders and representatives to develop and recommend evidence based practice models | | | | | | | | | | |
| **Task** 4. Collaborate with other project groups within the PPS project to strengthen engagement and representation with key stakeholders, providers and patients with emphasis on behavioral focused projects to raise their awareness that the outpatient detox centers exist and can see their patients. | | | | | | | | | | |
| **Task** 5. Adopt evidence based clinical and care pathways that include referral protocols to develop and strengthen collaborative care practices within the PPS. Submit approved pathways and referral process to the Clinical Integration & Quality committee for review. | | | | | | | | | | |
| **Task** 6. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | | | | | | | | | | |
| **Task** 7. Implement adopted and approved clinical guidelines and referral processes to identified sites and to participating providers | | | | | | | | | | |
| **Task** 8. Project team to make recommendations to the project medical director and Clinical Integration and Quality committee on best methods to track outcomes and indicators to measure effectiveness of withdrawal management processes | | | | | | | | | | |
| **Milestone #3** Include a project medical director, board certified in addiction medicine, with training and privileges for use of buprenorphine and buprenorphine/naltrexone as well as familiarity with other withdrawal management agents. | | | | | | | | | | |

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| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>PPS has designated at least one qualified and certified physician with training and privileges for use of buprenorphine/Naltrexone and other withdrawal agents. | | | | | | | | | | |
| **Task**<br>1. Develop a functional job description, with compensation and benefits methodology that links to workforce committee, who is board certified in addiction medicine, with training and privileges for use of buprenorphine and buprenorphine/naltrexone and other treatment modalities | | | | | | | | | | |
| **Task**<br>2. Recruit from existing network of stakeholders a project medical director as defined. Coordinate efforts with workforce strategies to widen search outside PPS provider network as necessary to recruit ideal candidate. | | | | | | | | | | |
| **Task**<br>3. Designate and retain contractually project medical director | | | | | | | | | | |
| **Task**<br>4. Participate with PPS as project liaison between PPS, project team and other projects within the organization | | | | | | | | | | |
| **Task**<br>5. Develop communication pathways for project medical director to guide project development, measure and report outcomes and initiate change if required. | | | | | | | | | | |
| **Milestone #4**<br>Identify and link to providers approved for outpatient medication management of opioid addiction who agree to provide continued maintenance therapy and collaborate with the treatment program and care manager. These may include practices with collocated behavioral health services, opioid treatment programs or outpatient SUD clinics. | | | | | | | | | | |
| **Task**<br>PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients. | 0 | 0 | 0 | 0 | 0 | 0 | 137 | 228 | 342 | 479 |
| **Task**<br>PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients. | 0 | 0 | 0 | 0 | 0 | 0 | 97 | 162 | 243 | 340 |
| **Task**<br>PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 6 | 9 | 13 |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| target patients. | | | | | | | | | | |
| **Task** PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients. | 0 | 0 | 0 | 0 | 0 | 0 | 27 | 45 | 68 | 95 |
| **Task** PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients. | 0 | 0 | 0 | 0 | 0 | 0 | 5 | 9 | 13 | 18 |
| **Task** 1. Project team and Medical Director to collaborate with identification of stakeholders and form task force to link to providers for outpatient withdrawal management services | | | | | | | | | | |
| **Task** 2. Complete current state assessment of participating providers and programs and to determine current services and current clinical state | | | | | | | | | | |
| **Task** 3. Link to evidence based approved protocols for triage, assessments, determination of appropriateness of care and referrals | | | | | | | | | | |
| **Task** 4. Establish relationships with identified providers and programs, review participating list and modify as necessary to reflect available resources | | | | | | | | | | |
| **Task** 5. Integrate protocols and pathways with related projects, specifically co-location of behavioral health services, ED Care triage and other projects within the PPS to establish collaboration and integrate protocols/criteria of project | | | | | | | | | | |
| **Milestone #5** Develop community-based withdrawal management (ambulatory detoxification) protocols based upon evidence based best practices and staff training. | | | | | | | | | | |
| **Task** Coordinated evidence-based care protocols are in place for community withdrawal management services. | | | | | | | | | | |
| **Task** Staff are trained on community-based withdrawal management protocols and care coordination procedures. | | | | | | | | | | |
| **Task** 1. Identify sites and practitioners that will participate in | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| community withdrawal management services | | | | | | | | | | |
| **Task** 2. Convene project team with guidance from project medical director to review, select and apply protocols to designated programs | | | | | | | | | | |
| **Task** 3. Develop project work flow for triage, assessment, and determination of appropriate level of care | | | | | | | | | | |
| **Task** 4. Project team and project medical director to make recommendations to workforce committee regarding workforce and training needs specific to the delivery of ambulatory withdrawal management, including care coordination and connection to treatment programs | | | | | | | | | | |
| **Task** 5. Explore opportunities to provide clients with 24 hour access to services; either through hotline or other forms of communication | | | | | | | | | | |
| **Task** 6. Explore transportation services in area to bolster transitions between levels of care and from community to program sites and develop transportation plan | | | | | | | | | | |
| **Task** 7. Adapt evidence based protocols for withdrawal management as necessary to support provider engagement | | | | | | | | | | |
| **Task** 8. Develop staff training protocols for care coordination that includes ability to address detox from alcohol, opiates, and sedatives, differentiation between withdrawal management agents, assessment and evaluation of behavioral health needs, and referral processes | | | | | | | | | | |
| **Task** 9. Develop staff training modules that reflect that training reflects co-occurring issues | | | | | | | | | | |
| **Task** 10. Offer and track training opportunities through a learning management system (LMS) to include cultural aspects of care and health literacy issues focusing on withdrawal management, substance abuse & behavioral health. | | | | | | | | | | |
| **Milestone #6** Develop care management services within the SUD treatment program. | | | | | | | | | | |
| **Task** Coordinated evidence-based care protocols are in place for care management services within SUD treatment program. | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task** Staff are trained to provide care management services within SUD treatment program. | | | | | | | | | | |
| **Task** 1. Identify appropriate current state provider(s) for care management services within the SUD treatment programs | | | | | | | | | | |
| **Task** 2. Convene care management providers to establish linkages to treatment and stepped levels of care for care coordination and treatment to facilitate engagement | | | | | | | | | | |
| **Task** 3. Adapt existing evidence-based protocols for withdrawal management to support care coordination and connection to treatment | | | | | | | | | | |
| **Task** 4. Recommend care management service protocols through Clinical Integration committee of PPS, to coordinate with providers, outpatient services, Health homes and behavioral health support services as necessary | | | | | | | | | | |
| **Task** 5. Identify community support resources, including transportation, child care, housing and employment training to care managers to use as resources | | | | | | | | | | |
| **Task** 6. Offer and track training and education opportunities through a learning management system to include cultural aspects of care and health literacy issues focusing on withdrawal management | | | | | | | | | | |
| **Task** 7. Project subcommittee and project medical director to make recommendations to Clinical Integration and Quality committees of PPS best methods to track outcomes and revise as necessary | | | | | | | | | | |
| **Milestone #7** Form agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project. | | | | | | | | | | |
| **Task** PPS has engaged MCO to develop protocols for coordination of services under this project. | | | | | | | | | | |
| **Task** 1. Review the ambulatory detoxification program and protocols with MCO's in the region and review benefit designs and options for payment for ambulatory detox services. | | | | | | | | | | |
| **Task** 2. Review prior authorization processes for withdrawal services and clarify member eligibility criteria for services. | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>3. Develop benefit coverage design with MCO's | | | | | | | | | | |
| **Task**<br>4. Identify any issues that need to be raised with DOH for policy changes. | | | | | | | | | | |
| **Task**<br>5. Develop contracting strategy on behalf of the PPS and its partners relative to this project. | | | | | | | | | | |
| **Milestone #8**<br>Use EHRs or other technical platforms to track all patients engaged in this project. | | | | | | | | | | |
| **Task**<br>PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. | | | | | | | | | | |
| **Task**<br>1. Determine requirements for identification of targeted patients and tracking actively engaged patients per state-provided specifications for the DSRIP program. | | | | | | | | | | |
| **Task**<br>2. Review strategies and tools needed to promote DSRIP specific Patient Engagement | | | | | | | | | | |
| **Task**<br>3. Working with the project team document current and future state work flow in addition to capturing manual solutions in place at this time. | | | | | | | | | | |
| **Task**<br>4. Assess current EHR and other technical platforms in the PPS against established requirements for patient identification and tracking, system notification, and treatment plan creation. | | | | | | | | | | |
| **Task**<br>5. Create a gap analysis based on the work flow analysis to determine incremental IT needs and associated budget, including short-term manual solutions. | | | | | | | | | | |
| **Task**<br>6. Identify prioritization of systems to build or associated change with separate work streams focused on implementing new Electronic Health Record Systems vs. RHIO connectivity based on the DSRIP project needs and associated providers' needs | | | | | | | | | | |
| **Task**<br>7. Develop a roll-out plan for systems to achieve clinical data sharing, including a training plan to support the successful implementation of new platforms and processes | | | | | | | | | | |
| **Task**<br>8. Establish a process for monitoring project milestones and performance. | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>9. Where electronic functionality is not yet ready, implement alternate in the interim and track conversion to electronic systems. | | | | | | | | | | |
| **Task**<br>10. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS. | | | | | | | | | | |
| **Task**<br>11. Develop a process for determining how success will be measured that incorporates feedback from practitioners and other key users of IT, including financial and patient engagement impact and risks. | | | | | | | | | | |

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Milestone #1**<br>Develop community-based addiction treatment programs that include outpatient SUD sites with PCP integrated teams, and stabilization services including social services. | | | | | | | | | | |
| **Task**<br>PPS has developed community-based addiction treatment programs that include outpatient SUD sites, PCP integrated teams, and stabilization services. | | | | | | | | | | |
| **Task**<br>1. Identify project lead at PPS level | | | | | | | | | | |
| **Task**<br>2. Form project teams, including behavorial service providers, residential providers, hospitals, outpatient service providers, withdrawal management service representatives, administrative and front line staff and PPS representatives | | | | | | | | | | |
| **Task**<br>3. Confirm provider and/or sites for community-based addictions services program (St. Peter's Health Partners, St. Mary's Troy, St. Mary's Outpatient-Amsterdam, SPARC Cohoes, SPARC Central Ave, SPARC Guilderland Equinox, Belvedere, Conifer Glenville & Conifer Troy) | | | | | | | | | | |
| **Task**<br>4. Assess current state withdrawal management services, including outpatient SUD sites with PCP integrated teams capabilities | | | | | | | | | | |
| **Task**<br>5. Consider an assessment of clinical, recovery and peer support service provider staff and resources that would be required to implement the project | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task** 6. Recognize any geographical gap in services within community based programs | | | | | | | | | | |
| **Task** 7. Include key partners in project planning including OASAS, social service providers, criminal justice, public health, health centers, urgent care centers, intervention hotlines, housing representatives and other representatives | | | | | | | | | | |
| **Task** 8. Project team to make recommendations PPS to confirmed sites for community-based addiction treatment (refer to # 3 above) | | | | | | | | | | |
| **Task** 9. PPS has requested licensure or waivers necessary to perform withdrawal management services | | | | | | | | | | |
| **Task** 10. PPS has referral and care coordination agreements in place with providers and community partners within the PPS | | | | | | | | | | |
| **Task** 11. Align program with OASAS levels of care | | | | | | | | | | |
| **Task** 12. Determine hours of operation that will minimize gaps in services | | | | | | | | | | |
| **Task** 13. Define future state of the withdrawal management program and develop plans to address gaps in services if identified | | | | | | | | | | |
| **Task** 14. Coordinate with other projects within the PPS, such as the ED Care Triage project, integration of primary care and behavioral health services and PCMH requirements | | | | | | | | | | |
| **Task** 15. Implement clinical guidelines and processes to provide stabilization services | | | | | | | | | | |
| **Task** 16. Coordinate with PCP practice based withdrawal management and maintenance clinical pathways and care models | | | | | | | | | | |
| **Task** 17. Track and evaluate programs at each site using rapid cycle evaluation techniques | | | | | | | | | | |
| **Task** 18. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | | | | | | | | | | |
| **Milestone #2** Establish referral relationships between community treatment | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| programs and inpatient detoxification services with development of referral protocols. | | | | | | | | | | |
| **Task** PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients. | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 |
| **Task** PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients. | 95 | 95 | 95 | 95 | 95 | 95 | 95 | 95 | 95 | 95 |
| **Task** PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients. | 18 | 18 | 18 | 18 | 18 | 18 | 18 | 18 | 18 | 18 |
| **Task** Regularly scheduled formal meetings are held to develop collaborative care practices among community treatment programs as well as between community treatment programs and inpatient detoxification facilities. | | | | | | | | | | |
| **Task** Coordinated evidence-based care protocols are in place for community withdrawal management services. Protocols include referral procedures. | | | | | | | | | | |
| **Task** 1. Identify current state inpatient detoxification services and community treatment program stakeholders | | | | | | | | | | |
| **Task** 2. Establish referral relationships with a focus on withdrawal management practice capacity | | | | | | | | | | |
| **Task** 3. Initiate and conduct regularly scheduled meetings with relevant agendas for identified stakeholders and representatives to develop and recommend evidence based practice models | | | | | | | | | | |
| **Task** 4. Collaborate with other project groups within the PPS project to strengthen engagement and representation with key stakeholders, providers and patients with emphasis on behavioral focused projects to raise their awareness that the outpatient detox centers exist and can see their patients. | | | | | | | | | | |
| **Task** 5. Adopt evidence based clinical and care pathways that include referral protocols to develop and strengthen collaborative care | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| practices within the PPS. Submit approved pathways and referral process to the Clinical Integration & Quality committee for review. | | | | | | | | | | |
| **Task**<br>6. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | | | | | | | | | | |
| **Task**<br>7. Implement adopted and approved clinical guidelines and referral processes to identified sites and to participating providers | | | | | | | | | | |
| **Task**<br>8. Project team to make recommendations to the project medical director and Clinical Integration and Quality committee on best methods to track outcomes and indicators to measure effectiveness of withdrawal management processes | | | | | | | | | | |
| **Milestone #3**<br>Include a project medical director, board certified in addiction medicine, with training and privileges for use of buprenorphine and buprenorphine/naltrexone as well as familiarity with other withdrawal management agents. | | | | | | | | | | |
| **Task**<br>PPS has designated at least one qualified and certified physician with training and privileges for use of buprenorphine/Naltrexone and other withdrawal agents. | | | | | | | | | | |
| **Task**<br>1. Develop a functional job description, with compensation and benefits methodology that links to workforce committee, who is board certified in addiction medicine, with training and privileges for use of buprenorphine and buprenorphine/naltrexone and other treatment modalities | | | | | | | | | | |
| **Task**<br>2. Recruit from existing network of stakeholders a project medical director as defined. Coordinate efforts with workforce strategies to widen search outside PPS provider network as necessary to recruit ideal candidate. | | | | | | | | | | |
| **Task**<br>3. Designate and retain contractually project medical director | | | | | | | | | | |
| **Task**<br>4. Participate with PPS as project liaison between PPS, project team and other projects within the organization | | | | | | | | | | |
| **Task**<br>5. Develop communication pathways for project medical director to guide project development, measure and report outcomes and initiate change if required. | | | | | | | | | | |
| **Milestone #4**<br>Identify and link to providers approved for outpatient medication management of opioid addiction who agree to provide continued | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| maintenance therapy and collaborate with the treatment program and care manager. These may include practices with collocated behavioral health services, opioid treatment programs or outpatient SUD clinics. | | | | | | | | | | |
| **Task** PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients. | 479 | 479 | 479 | 479 | 479 | 479 | 479 | 479 | 479 | 479 |
| **Task** PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients. | 340 | 340 | 340 | 340 | 340 | 340 | 340 | 340 | 340 | 340 |
| **Task** PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients. | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 |
| **Task** PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients. | 95 | 95 | 95 | 95 | 95 | 95 | 95 | 95 | 95 | 95 |
| **Task** PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients. | 18 | 18 | 18 | 18 | 18 | 18 | 18 | 18 | 18 | 18 |
| **Task** 1. Project team and Medical Director to collaborate with identification of stakeholders and form task force to link to providers for outpatient withdrawal management services | | | | | | | | | | |
| **Task** 2. Complete current state assessment of participating providers and programs and to determine current services and current clinical state | | | | | | | | | | |
| **Task** 3. Link to evidence based approved protocols for triage, assessments, determination of appropriateness of care and referrals | | | | | | | | | | |
| **Task** 4. Establish relationships with identified providers and programs, review participating list and modify as necessary to reflect available resources | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>5. Integrate protocols and pathways with related projects, specifically co-location of behavioral health services, ED Care triage and other projects within the PPS to establish collaboration and integrate protocols/criteria of project | | | | | | | | | | |
| **Milestone #5**<br>Develop community-based withdrawal management (ambulatory detoxification) protocols based upon evidence based best practices and staff training. | | | | | | | | | | |
| **Task**<br>Coordinated evidence-based care protocols are in place for community withdrawal management services. | | | | | | | | | | |
| **Task**<br>Staff are trained on community-based withdrawal management protocols and care coordination procedures. | | | | | | | | | | |
| **Task**<br>1. Identify sites and practitioners that will participate in community withdrawal management services | | | | | | | | | | |
| **Task**<br>2. Convene project team with guidance from project medical director to review, select and apply protocols to designated programs | | | | | | | | | | |
| **Task**<br>3. Develop project work flow for triage, assessment, and determination of appropriate level of care | | | | | | | | | | |
| **Task**<br>4. Project team and project medical director to make recommendations to workforce committee regarding workforce and training needs specific to the delivery of ambulatory withdrawal management, including care coordination and connection to treatment programs | | | | | | | | | | |
| **Task**<br>5. Explore opportunities to provide clients with 24 hour access to services; either through hotline or other forms of communication | | | | | | | | | | |
| **Task**<br>6. Explore transportation services in area to bolster transitions between levels of care and from community to program sites and develop transportation plan | | | | | | | | | | |
| **Task**<br>7. Adapt evidence based protocols for withdrawal management as necessary to support provider engagement | | | | | | | | | | |
| **Task**<br>8. Develop staff training protocols for care coordination that includes ability to address detox from alcohol, opiates, and sedatives, differentiation between withdrawal management | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| agents, assessment and evaluation of behavioral health needs, and referral processes | | | | | | | | | | |
| **Task** 9. Develop staff training modules that reflect that training reflects co-occurring issues | | | | | | | | | | |
| **Task** 10. Offer and track training opportunities through a learning management system (LMS) to include cultural aspects of care and health literacy issues focusing on withdrawal management, substance abuse & behavioral health. | | | | | | | | | | |
| **Milestone #6** Develop care management services within the SUD treatment program. | | | | | | | | | | |
| **Task** Coordinated evidence-based care protocols are in place for care management services within SUD treatment program. | | | | | | | | | | |
| **Task** Staff are trained to provide care management services within SUD treatment program. | | | | | | | | | | |
| **Task** 1. Identify appropriate current state provider(s) for care management services within the SUD treatment programs | | | | | | | | | | |
| **Task** 2. Convene care management providers to establish linkages to treatment and stepped levels of care for care coordination and treatment to facilitate engagement | | | | | | | | | | |
| **Task** 3. Adapt existing evidence-based protocols for withdrawal management to support care coordination and connection to treatment | | | | | | | | | | |
| **Task** 4. Recommend care management service protocols through Clinical Integration committee of PPS, to coordinate with providers, outpatient services, Health homes and behavioral health support services as necessary | | | | | | | | | | |
| **Task** 5. Identify community support resources, including transportation, child care, housing and employment training to care managers to use as resources | | | | | | | | | | |
| **Task** 6. Offer and track training and education opportunities through a learning management system to include cultural aspects of care and health literacy issues focusing on withdrawal management | | | | | | | | | | |
| **Task** 7. Project subcommittee and project medical director to make | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| recommendations to Clinical Integration and Quality committees of PPS best methods to track outcomes and revise as necessary | | | | | | | | | | |
| **Milestone #7** Form agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project. | | | | | | | | | | |
| **Task** PPS has engaged MCO to develop protocols for coordination of services under this project. | | | | | | | | | | |
| **Task** 1. Review the ambulatory detoxification program and protocols with MCO's in the region and review benefit designs and options for payment for ambulatory detox services. | | | | | | | | | | |
| **Task** 2. Review prior authorization processes for withdrawal services and clarify member eligibility criteria for services. | | | | | | | | | | |
| **Task** 3. Develop benefit coverage design with MCO's | | | | | | | | | | |
| **Task** 4. Identify any issues that need to be raised with DOH for policy changes. | | | | | | | | | | |
| **Task** 5. Develop contracting strategy on behalf of the PPS and its partners relative to this project. | | | | | | | | | | |
| **Milestone #8** Use EHRs or other technical platforms to track all patients engaged in this project. | | | | | | | | | | |
| **Task** PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. | | | | | | | | | | |
| **Task** 1. Determine requirements for identification of targeted patients and tracking actively engaged patients per state-provided specifications for the DSRIP program. | | | | | | | | | | |
| **Task** 2. Review strategies and tools needed to promote DSRIP specific Patient Engagement | | | | | | | | | | |
| **Task** 3. Working with the project team document current and future state work flow in addition to capturing manual solutions in place at this time. | | | | | | | | | | |
| **Task** 4. Assess current EHR and other technical platforms in the PPS against established requirements for patient identification and | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| tracking, system notification, and treatment plan creation. | | | | | | | | | | |
| **Task** 5. Create a gap analysis based on the work flow analysis to determine incremental IT needs and associated budget, including short-term manual solutions. | | | | | | | | | | |
| **Task** 6. Identify prioritization of systems to build or associated change with separate work streams focused on implementing new Electronic Health Record Systems vs. RHIO connectivity based on the DSRIP project needs and associated providers' needs | | | | | | | | | | |
| **Task** 7. Develop a roll-out plan for systems to achieve clinical data sharing, including a training plan to support the successful implementation of new platforms and processes | | | | | | | | | | |
| **Task** 8. Establish a process for monitoring project milestones and performance. | | | | | | | | | | |
| **Task** 9. Where electronic functionality is not yet ready, implement alternate in the interim and track conversion to electronic systems. | | | | | | | | | | |
| **Task** 10. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS. | | | | | | | | | | |
| **Task** 11. Develop a process for determining how success will be measured that incorporates feedback from practitioners and other key users of IT, including financial and patient engagement impact and risks. | | | | | | | | | | |

### Prescribed Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|

No Records Found

### Prescribed Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|
| Develop community-based addiction treatment programs that include outpatient SUD sites with PCP integrated teams, and | Tasks 3 and 4 originally dated 12/31/2015 have been moved to 3/31/2016. Tasks 5 and 6 originally dated 12/31/2015 have been moved to 6/30/2016. These changes reflect the ongoing nature of the work. |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Prescribed Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|
| stabilization services including social services. | |
| Establish referral relationships between community treatment programs and inpatient detoxification services with development of referral protocols. | Tasks 1 and 2 originally dated 12/31/2015 have been moved to 3/31/2016. Task 3 originally dated 12/31/2015 has been moved to 6/30/2016. These changes reflect the ongoing nature of the work. |
| Include a project medical director, board certified in addiction medicine, with training and privileges for use of buprenorphine and buprenorphine/naltrexone as well as familiarity with other withdrawal management agents. | Task 1 originally dated 12/31/2015 has been moved to 9/30/2016. Task 2 originally dated 12/31/2015 has been moved to 12/31/2016. These changes reflect the ongoing nature of the work. |
| Identify and link to providers approved for outpatient medication management of opioid addiction who agree to provide continued maintenance therapy and collaborate with the treatment program and care manager. These may include practices with collocated behavioral health services, opioid treatment programs or outpatient SUD clinics. | |
| Develop community-based withdrawal management (ambulatory detoxification) protocols based upon evidence based best practices and staff training. | Task 1 originally dated 12/31/2015 has been moved to 3/31/2016 to reflect the ongoing nature of the work. |
| Develop care management services within the SUD treatment program. | |
| Form agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project. | |
| Use EHRs or other technical platforms to track all patients engaged in this project. | |

### Milestone Review Status

| Milestone # | Review Status | IA Formal Comments |
|---|---|---|
| **Milestone #1** | Pass & Ongoing | |
| **Milestone #2** | Pass & Ongoing | |
| **Milestone #3** | Pass & Ongoing | |
| **Milestone #4** | Pass & Ongoing | |
| **Milestone #5** | Pass & Ongoing | |
| **Milestone #6** | Pass & Ongoing | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Milestone Review Status

| Milestone # | Review Status | IA Formal Comments |
|---|---|---|
| **Milestone #7** | Pass & Ongoing | |
| **Milestone #8** | Pass & Ongoing | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 3.a.iv.4 - PPS Defined Milestones

**Instructions :**

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for PPS-defined milestones.

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|

No Records Found

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC  (PPS ID:3)

**IPQR Module 3.a.iv.5 - IA Monitoring**

**Instructions :**

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Project 3.d.ii – Expansion of asthma home-based self-management program

#### IPQR Module 3.d.ii.1 - Major Risks to Implementation and Mitigation Strategies

**Instructions :**

Please describe what the major risks are for this project, as well as the actions you plan to take to mitigate them.

Reimbursement practices are a key risk to provider engagement in this project. For example, MCO policies do not cover multiple prescriptions for the same inhaler so that inhalers can be simultaneously available at home, school, and other family member locations. Building on PPS partnership agreements with the regional MCO's, the PPS will mitigate this risk by advocating for enhanced coverage of home-based self-management that has been shown to reduce overall burden of asthma costs. Success of the mitigation strategy will be seen when MCO/PPS agreements have been made.
There are many IT Risks, such as data interoperability using multiple vendors that may not support existing standards- the risk mitigation strategy is to engage vendors early & determine supplemental solutions if available. The RHIO (the expected interoperable clinical platform) has expressed limitations on data sharing per NY state policies, working with EHR vendors to achieve data sharing & balancing DSRIP needs with existing commitments. Population Health IT (PHIT) systems & tools are required & delay to PHIT implementation delays the projects & risks not meeting speed/scale requirements. PHIT depends on sufficient capital funding from NY state & delay in capital release will delay the rollout. The PPS will work with the RHIO, accelerate implementation of PHIT interoperability, use alternate methods where EHRs & PHIT tool functionality aren't ready & work with NY to ensure capital is given in sufficient time.

Care of asthma patients and the transition and/or expansion of home based self-management program needs to not only educate and increase awareness for the patient, caregivers, families, environment, and schools, but must also link to care transitions. The PPS will form an asthma task force to develop and coordinate in-services to educate providers and care managers about community-based resources and referrals. Traditional providers need to be linked with home-based programs and community health workers to minimize missed opportunities for home visits and access to patient homes; if not the project has an increased risk of resistance to change and stagnation in current state management. The AFBHC will leverage its active partnership with the Asthma Coalition, Asthma Support Groups and School-Based Asthma Management program to ensure equal resources are available throughout the geographic region. Engaging patients in their care will also be important to the success of this project. The PPS will develop strategies to provide culturally and linguistically appropriate care by hiring individuals who are representative of the patient population, and by leveraging CHW's and community asthma champions. Success of the program will be measured by a decrease in emergency asthma visits to ED, and an increase in community participation of various community based organization, clinics, health care organizations and pharmacies. Additionally, awareness of PCPs and non-PCPs will be measured and tracked by determining where patients' referrals originated (asthma registry and IT platforms). The PPS will also engage the marketing and communication committees to help with awareness and tactics for improving home management of respiratory complaints. Ideally, this project's success could also be measured with the success of tobacco use cessation project 4.b.i, since cessation in tobacco use can be correlated to a reduction in environmental triggers. The interplay between these projects will be tracked during the DSRIP project.

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 3.d.ii.2 - Patient Engagement Speed

**Instructions :**

Enter the number of patients actively engaged through the current quarter. The number entered into the "Patient Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for DY1 Q3 should include patients previously reported in DY1 Q2 plus new patients engaged in DY1 Q3. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

| Benchmarks | |
|---|---|
| **100% Actively Engaged By** | **Expected Patient Engagement** |
| DY4,Q4 | 11,007 |

| Patients Engaged to Date in Current DY | DY1,Q3 Patient Update | % of Semi-Annual Commitment To-Date | Semi-Annual Variance of Projected to Actual | % of Total Actively Engaged Patients To-Date |
|---|---|---|---|---|
| 0 | 0 | 0.00% | 2,858 | 0.00% |

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (2,858)

### Current File Uploads

| User ID | File Type | File Name | File Description | Upload Date |
|---|---|---|---|---|
| cdomeier | Communication Documentation | 3_PMDL4715_1_3_20160129161105_DY1Q3_absense_of_patient_registry_explanation.docx | Explanation for absence of DY1, Q3 Patient Update | 01/29/2016 04:11 PM |

**Narrative Text :**

For PPS to provide additional context regarding progress and/or updates to IA.

### Module Review Status

| Review Status | IA Formal Comments |
|---|---|
| Fail | The PPS failed to meet at least 80% of its actively engaged commitments for DY1Q3. The documentation does not support the reported actively engaged numbers. |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 3.d.ii.3 - Prescribed Milestones

**Instructions :**

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for prescribed milestones. For milestones that are due and completed within the reporting period, documentation is required to provide evidence of project requirement achievement. Any explanations regarding altered or missed provider commitments should be included within the narrative box, not as text within uploaded documentation.

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| **Milestone #1** Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up. | Project | N/A | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** PPS has developed a strategy for the collaboration of community medical and social services providers to assess a patient's home and provide self-management education for the appropriate control of asthma. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 1. Using CNA results and population health tools, hot spot asthma diagnoses in the covered 6 county region | Project | | In Progress | 04/01/2015 | 03/31/2016 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 2. Develop strategy to collaborate with neighboring PPS (see # 3 below) that selected projects asthma and tobacco use cessation projects | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 3. Identify opportunities for collaboration with neighboring PPS's such as Albany Medical Center & Adirondack Health Institute. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 4. Integrate project plan components with PPS projects that influence outcomes and collaborate with surrounding communities and other PPS as necessary | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 5. Identify project lead at PPS level | Project | | Completed | 07/01/2015 | 12/31/2015 | 07/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 |
| **Task** 6. Identify those provider and/or sites, including PCPs, home care providers, health homes, pharmacies, school health and hospital that support the activities of the Asthma self-management program | Project | | Completed | 07/01/2015 | 12/31/2015 | 07/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| **Task** 7. Finalize Contract/MOUs with PCP practices and community providers | Project | | In Progress | 07/01/2015 | 12/31/2015 | 07/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task** 8. Assess providers to determine current home based asthma programs, range of services provided, and referral mechanisms for identified patients. | Project | | Completed | 07/01/2015 | 12/31/2015 | 07/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 |
| **Task** 9. Examine data to identify hot spotting areas for common asthma triggers in the identified population | Project | | In Progress | 07/01/2015 | 12/31/2016 | 07/01/2015 | 12/31/2016 | 12/31/2016 | DY2 Q3 |
| **Task** 10. Target areas for the project utilizing hot spotting and assessment. | Project | | Completed | 07/01/2015 | 12/31/2015 | 07/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 |
| **Task** 11. Phase roll-out of project plans to coincide with in place resources | Project | | In Progress | 10/01/2015 | 03/31/2018 | 10/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 12. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | Project | | In Progress | 10/01/2015 | 03/31/2018 | 10/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 13. Finalize strategy for expanding home-based asthma self-management program | Project | | In Progress | 10/31/2015 | 06/30/2016 | 10/31/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task** 14. Implement clinical guidelines and processes | Project | | In Progress | 12/01/2015 | 03/31/2018 | 12/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 15. Track and evaluate programs roll out using rapid cycle team evaluation techniques | Project | | In Progress | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 9-24-15 Remediation Response 16. Identify entities & agencies that will be implementing home based medical and social services, including current providers | Project | | In Progress | 09/24/2015 | 03/31/2016 | 09/24/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 9-24-15 Remediation Response 17. Develop strategy with workforce team to identify gaps in needed community providers, monitor progress of filling gaps & identifying training opportunities to minimize shortages. | Project | | In Progress | 09/24/2015 | 12/31/2016 | 09/24/2015 | 12/31/2016 | 12/31/2016 | DY2 Q3 |
| **Task** 9-24-15 Remediation Responses 18. Develop strategy for systematic rollout of home assessment | Project | | In Progress | 09/24/2015 | 12/31/2016 | 09/24/2015 | 12/31/2016 | 12/31/2016 | DY2 Q3 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| workforce into the community to enhance home assessments & follow ups. | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>19. Develop plan for referral process from primary care & medical facilities that encounter asthma patients to community medical and social service providers, including process for feedback and improvement to referring entity. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #2**<br>Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>PPS has developed intervention protocols and identified resources in the community to assist patients with needed evidence-based trigger reduction interventions. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>1. Identify project lead and clinical support team for project potentially utilizing members from the project implementation groups | Project | | Completed | 07/01/2015 | 12/31/2015 | 07/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 |
| **Task**<br>2. Select procedures and intervention protocols for project | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task**<br>3. Partner with resources such as the Asthma Coalition to fill in gaps if indicated | Project | | Completed | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 |
| **Task**<br>4. Present recommendations to the Clinical Integration and Quality committee of the PPS on project methodology | Project | | In Progress | 07/01/2015 | 12/31/2015 | 07/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task**<br>5. Develop strategy to partner with community resources, such as pest control and housing to link clients with resources available for reducing environmental asthma triggers | Project | | In Progress | 07/01/2015 | 12/31/2015 | 07/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task**<br>6. Develop plans with the tobacco cessation project (4 b i) to reduce second hand smoke as an asthma trigger and connect engaged patients and families with tobacco cessation tools and education. | Project | | In Progress | 07/01/2015 | 12/31/2016 | 07/01/2015 | 12/31/2016 | 12/31/2016 | DY2 Q3 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| **Task** 7. Collaborate with the cultural competency & health literacy committee to establish age appropriate, culturally sensitive interventions to engage clients | Project | | In Progress | 07/01/2015 | 03/31/2017 | 07/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 8. Collaborate with the workforce committee to leverage workforce resources such as community health workers (CHW) to engage clients | Project | | In Progress | 07/01/2015 | 03/31/2017 | 07/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 9. Partner with community resources, such as the Asthma Coalition, to create a resource directory for clients (not limited to mold, mites, dust, roaches, pets, etc) | Project | | In Progress | 07/01/2015 | 03/31/2017 | 07/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #3** Develop and implement evidence-based asthma management guidelines. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** PPS incorporates evidence-based guidelines that are periodically evaluated and revised, if necessary, in the design and implementation of asthma management. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 1. Identify nationally recognized evidence based guidelines such as NHLBI and/or EPR3 for asthma management, medication management and care pathways. Additionally, coordinate efforts with the Albany Medical Center Evidenced-Based Medicine Asthma guidelines DSRIP Project already created to align common efforts where the 2 projects overlaps | Project | | In Progress | 07/01/2015 | 12/31/2016 | 07/01/2015 | 12/31/2016 | 12/31/2016 | DY2 Q3 |
| **Task** 2. Submit clinical guideline recommendations to the Clinical Integration & Quality committee for approval | Project | | In Progress | 07/01/2015 | 12/31/2016 | 07/01/2015 | 12/31/2016 | 12/31/2016 | DY2 Q3 |
| **Task** 3. Identify indoor trigger control guidelines from recognized entities such as the EPA and other environmental improvement agencies | Project | | In Progress | 07/01/2015 | 03/31/2017 | 07/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 4. Implement adopted guidelines into participating sites and providers. | Project | | In Progress | 07/01/2016 | 12/31/2016 | 07/01/2016 | 12/31/2016 | 12/31/2016 | DY2 Q3 |
| **Task** 5. Track and evaluate programs roll out using rapid cycle team evaluation techniques | Project | | In Progress | 07/01/2016 | 03/31/2017 | 07/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| **Task** 6. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | Project | | In Progress | 07/01/2016 | 03/31/2017 | 07/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 7. Communicate with asthma project providers level of success of program quarterly | Project | | In Progress | 07/01/2016 | 03/31/2017 | 07/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #4** Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** PPS has developed training and comprehensive asthma self-management education, to include basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 1. Project team to evaluate and choose age appropriate education model for asthma home-based self-management. | Project | | In Progress | 09/01/2015 | 03/31/2017 | 09/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 2. Identify and/or develop asthma education materials | Project | | In Progress | 09/01/2015 | 03/31/2017 | 09/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 3. Ensure materials are aligned with age-appropriate culturally competency and health literacy strategy. | Project | | In Progress | 09/01/2015 | 03/31/2017 | 09/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 4. Present training and education material recommendations to the workforce committee for integration into the learning management system (LMS) | Project | | In Progress | 09/01/2015 | 03/31/2017 | 09/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 5. Present training and education material recommendations to the cultural competency and health literacy task force for acceptance | Project | | In Progress | 09/01/2015 | 03/31/2017 | 09/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 6. Develop roadmap for asthma training for providers | Project | | In Progress | 09/01/2015 | 03/31/2017 | 09/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 7. Consider training across projects to increase awareness of | Project | | In Progress | 09/01/2015 | 03/31/2017 | 09/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| asthma management and triggers with all providers | | | | | | | | | |
| **Task** 8. Include and enlist community health coaches for training sessions for continuity of education | Project | | In Progress | 09/01/2015 | 03/31/2017 | 09/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 9. Educate school based programs on project goals and their roles (eg- American Academy of Pediatrics use and feedback, school referrals to home-based self-management, etc.) | Project | | In Progress | 09/01/2015 | 03/31/2017 | 09/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 10. Include asthma action plan templates for home care and process to track use at home and school (including triggers) | Project | | In Progress | 09/01/2015 | 03/31/2017 | 09/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 11. Evaluate LMS for training platform for asthma self-management and other IT training solutions. | Project | | In Progress | 09/01/2015 | 03/31/2017 | 09/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 12. Track and evaluate programs roll out using rapid cycle team evaluation techniques | Project | | In Progress | 09/01/2015 | 03/31/2017 | 09/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 13. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | Project | | In Progress | 09/01/2015 | 03/31/2017 | 09/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #5** Ensure coordinated care for asthma patients includes social services and support. | Project | N/A | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** PPS has developed and conducted training of all providers, including social services and support. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** All practices in PPS have a Clinical Interoperability System in place for all participating providers. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** PPS has assembled a care coordination team that includes use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 1. Finalize Contract/MOUs with social service organizations | Project | | In Progress | 09/01/2015 | 12/31/2016 | 09/01/2015 | 12/31/2016 | 12/31/2016 | DY2 Q3 |
| **Task** 2. Finalize Contract/MOUs with members of asthma care | Project | | In Progress | 09/01/2015 | 12/31/2016 | 09/01/2015 | 12/31/2016 | 12/31/2016 | DY2 Q3 |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| coordination team, including school nurses, pharmacists, CHW, dieticians, home care agency staff, environment agencies, state supported agencies, housing | | | | | | | | | |
| **Task** 3. Finalize strategy for coordinating care and social services for the home-based asthma self-management program | Project | | In Progress | 09/01/2015 | 12/31/2016 | 09/01/2015 | 12/31/2016 | 12/31/2016 | DY2 Q3 |
| **Task** 4. Present recommendations to the Clinical Integration and Quality committee of the PPS on project methodology | Project | | In Progress | 09/01/2015 | 12/31/2016 | 09/01/2015 | 12/31/2016 | 12/31/2016 | DY2 Q3 |
| **Task** 5. Determine requirements for clinical interoperability within systems in regards to avoiding medication errors or duplicate services. | Project | | In Progress | 09/01/2015 | 12/31/2016 | 09/01/2015 | 12/31/2016 | 12/31/2016 | DY2 Q3 |
| **Task** 6. Project team to work with IT to determine clinical workflow and technology tools to incorporate into this project | Project | | In Progress | 09/01/2015 | 12/31/2016 | 09/01/2015 | 12/31/2016 | 12/31/2016 | DY2 Q3 |
| **Task** 7. Develop a roll-out plan for systems to achieve interoperability, including a training plan to support the successful implementation of new platforms and processes | Project | | In Progress | 09/01/2015 | 12/31/2016 | 09/01/2015 | 12/31/2016 | 12/31/2016 | DY2 Q3 |
| **Task** 8. Explore education programs including learning collaborative models, regional collaborative sessions and LMS for social service providers | Project | | In Progress | 09/01/2015 | 03/31/2018 | 09/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 9. Coordinate with IT roadmap for provider Clinical Interoperability System | Project | | In Progress | 09/01/2015 | 03/31/2018 | 09/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 10. Integrate communication avenues for medication reconciliation measures per IT roadmap | Project | | In Progress | 09/01/2015 | 03/31/2018 | 09/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 11. Appraise the availability of providing asthma education and certification funding to social service providers and schools to improve outcomes | Project | | In Progress | 12/01/2015 | 03/31/2018 | 12/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Milestone #6** Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| Follow-up services implemented after ED or hospital visit occurs. Root cause analysis is conducted and shared with patient's family. | | | | | | | | | |
| **Task** 1. Develop strategy for follow-up services after negative event, including consulting with partners that provide follow-up services | Project | | In Progress | 07/01/2015 | 12/31/2015 | 07/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task** 2. Finalize strategy for root cause analysis and teach back to patient and/or family, with focus of use of asthma action plan | Project | | In Progress | 07/01/2015 | 12/31/2015 | 07/01/2015 | 09/30/2016 | 09/30/2016 | DY2 Q2 |
| **Task** 3. Identify IT solutions for event notifications to project teams | Project | | In Progress | 07/01/2015 | 12/31/2015 | 07/01/2015 | 09/30/2016 | 09/30/2016 | DY2 Q2 |
| **Task** 4. Develop plan for project overlap education to ED care navigators, hospital to home providers, care transition providers, CHW, and other providers regarding RCA process and evolvement | Project | | In Progress | 12/01/2015 | 03/31/2017 | 12/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 5. Connect providers to RCA process and plans for provisions of feedback to avoid future events | Project | | In Progress | 12/01/2015 | 03/31/2017 | 12/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 6. Consider creating tool for patient/family that can be used at the ED visit or post discharge from hospital as part of asthma action plan | Project | | In Progress | 12/01/2015 | 03/31/2017 | 12/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 7. Present follow up services strategy to cultural competency & health literacy taskforce to align with overall strategies | Project | | In Progress | 12/01/2015 | 03/31/2017 | 12/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 8. Present follow up strategy to workforce committee to use as tool to determine workforce related gap in services, if appropriate | Project | | In Progress | 12/01/2015 | 03/31/2017 | 12/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 9. Track and evaluate programs roll out using RCA conclusions quarterly | Project | | In Progress | 12/01/2015 | 03/31/2017 | 12/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 10. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | Project | | In Progress | 12/01/2015 | 03/31/2017 | 12/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 11. Consider piloting Community Emergency Management Services (EMS) program to conduct home visits for education, self-management support to improve asthma home | Project | | In Progress | 03/31/2016 | 03/31/2017 | 03/31/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| management. Include information from EMS in home/environmental assessments | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>12. PPS will measure outcomes of the program and follow up services as determined by the Clinical Integration & Quality Committee to ensure optimal success by utilizing a continuous process improvement model. | Project | | In Progress | 09/24/2015 | 03/31/2017 | 09/24/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>9-24-15 Remediation Response<br>13. Quarterly outcome dashboards will be developed and reported to project teams, Clinical Integration & Quality Committee and goverance committees to track program success. | Project | | In Progress | 09/24/2015 | 03/31/2017 | 09/24/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #7**<br>Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers. | Project | N/A | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>PPS has established agreements with MCOs that address the coverage of patients with asthma health issues. PPS has established agreements with health home care managers, PCPs, and specialty providers. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>1. Identify from MCO's in the region if they offer asthma at home trigger reduction programs and self-management programs | Project | | In Progress | 03/31/2016 | 06/01/2016 | 03/31/2016 | 06/01/2016 | 06/30/2016 | DY2 Q1 |
| **Task**<br>2. Identify benefit offerings including covered drugs for asthma with protocols for their use | Project | | In Progress | 03/31/2016 | 06/01/2016 | 03/31/2016 | 06/01/2016 | 06/30/2016 | DY2 Q1 |
| **Task**<br>3. Compare AFBHC desired guidelines with health plan offerings and establish approach to increase or change coverage if required | Project | | In Progress | 03/31/2016 | 06/01/2016 | 03/31/2016 | 06/01/2016 | 06/30/2016 | DY2 Q1 |
| **Task**<br>4. Establish role of health plan, health home care managers, and primary care providers and include these roles in respective provider contracts. | Project | | In Progress | 03/31/2016 | 12/31/2016 | 03/31/2016 | 12/31/2016 | 12/31/2016 | DY2 Q3 |
| **Task**<br>5. Finalize Contract/MOUs with MCOs at PPS level, specific to | Project | | In Progress | 03/31/2016 | 03/31/2018 | 03/31/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| coverage of asthma health issue payments | | | | | | | | | |
| **Milestone #8** Use EHRs or other technical platforms to track all patients engaged in this project. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 1. Determine requirements for identification of targeted patients and tracking actively engaged patients per state-provided specifications for the DSRIP program. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 2. Review strategies and tools needed to promote DSRIP specific Patient Engagement | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 3. Working with the project team document current and future state work flow in addition to capturing manual solutions in place at this time. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 4. Assess current EHR and other technical platforms in the PPS against established requirements for patient identification and tracking, system notification, and treatment plan creation. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 5. Create a gap analysis based on the work flow analysis to determine incremental IT needs and associated budget, including short-term manual solutions. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 6. Identify prioritization of systems to build or associated change with separate work streams focused on implementing new Electronic Health Record Systems vs. RHIO connectivity based on the project needs and associated providers' needs | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 7. Develop a roll-out plan for systems to achieve clinical data sharing, including a training plan to support the successful implementation of new platforms and processes | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 8. Establish a process for monitoring project milestones and performance. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| 9. Where electronic functionality is not yet ready, implement alternate in the interim and track conversion to electronic systems. | | | | | | | | | |
| **Task**<br>10. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>11. Develop a process for determining how success will be measured that incorporates feedback from practitioners and other key users of IT, including financial and patient engagement impact and risks. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Milestone #1**<br>Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up. | | | | | | | | | | |
| **Task**<br>PPS has developed a strategy for the collaboration of community medical and social services providers to assess a patient's home and provide self-management education for the appropriate control of asthma. | | | | | | | | | | |
| **Task**<br>1. Using CNA results and population health tools, hot spot asthma diagnoses in the covered 6 county region | | | | | | | | | | |
| **Task**<br>2. Develop strategy to collaborate with neighboring PPS (see # 3 below) that selected projects asthma and tobacco use cessation projects | | | | | | | | | | |
| **Task**<br>3. Identify opportunities for collaboration with neighboring PPS's such as Albany Medical Center & Adirondack Health Institute. | | | | | | | | | | |
| **Task**<br>4. Integrate project plan components with PPS projects that influence outcomes and collaborate with surrounding communities and other PPS as necessary | | | | | | | | | | |
| **Task**<br>5. Identify project lead at PPS level | | | | | | | | | | |
| **Task**<br>6. Identify those provider and/or sites, including PCPs, home | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| care providers, health homes, pharmacies, school health and hospital that support the activities of the Asthma self-management program | | | | | | | | | | |
| **Task**<br>7. Finalize Contract/MOUs with PCP practices and community providers | | | | | | | | | | |
| **Task**<br>8. Assess providers to determine current home based asthma programs, range of services provided, and referral mechanisms for identified patients. | | | | | | | | | | |
| **Task**<br>9. Examine data to identify hot spotting areas for common asthma triggers in the identified population | | | | | | | | | | |
| **Task**<br>10. Target areas for the project utilizing hot spotting and assessment. | | | | | | | | | | |
| **Task**<br>11. Phase roll-out of project plans to coincide with in place resources | | | | | | | | | | |
| **Task**<br>12. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | | | | | | | | | | |
| **Task**<br>13. Finalize strategy for expanding home-based asthma self-management program | | | | | | | | | | |
| **Task**<br>14. Implement clinical guidelines and processes | | | | | | | | | | |
| **Task**<br>15. Track and evaluate programs roll out using rapid cycle team evaluation techniques | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>16. Identify entities & agencies that will be implementing home based medical and social services, including current providers | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>17. Develop strategy with workforce team to identify gaps in needed community providers, monitor progress of filling gaps & identifying training opportunities to minimize shortages. | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Responses<br>18. Develop strategy for systematic rollout of home assessment workforce into the community to enhance home assessments & follow ups. | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>9-24-15 Remediation Response<br>19. Develop plan for referral process from primary care & medical facilities that encounter asthma patients to community medical and social service providers, including process for feedback and improvement to referring entity. | | | | | | | | | | |
| **Milestone #2**<br>Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke. | | | | | | | | | | |
| **Task**<br>PPS has developed intervention protocols and identified resources in the community to assist patients with needed evidence-based trigger reduction interventions. | | | | | | | | | | |
| **Task**<br>1. Identify project lead and clinical support team for project potentially utilizing members from the project implementation groups | | | | | | | | | | |
| **Task**<br>2. Select procedures and intervention protocols for project | | | | | | | | | | |
| **Task**<br>3. Partner with resources such as the Asthma Coalition to fill in gaps if indicated | | | | | | | | | | |
| **Task**<br>4. Present recommendations to the Clinical Integration and Quality committee of the PPS on project methodology | | | | | | | | | | |
| **Task**<br>5. Develop strategy to partner with community resources, such as pest control and housing to link clients with resources available for reducing environmental asthma triggers | | | | | | | | | | |
| **Task**<br>6. Develop plans with the tobacco cessation project (4 b i) to reduce second hand smoke as an asthma trigger and connect engaged patients and families with tobacco cessation tools and education. | | | | | | | | | | |
| **Task**<br>7. Collaborate with the cultural competency & health literacy committee to establish age appropriate, culturally sensitive interventions to engage clients | | | | | | | | | | |
| **Task**<br>8. Collaborate with the workforce committee to leverage workforce resources such as community health workers (CHW) to engage clients | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>9. Partner with community resources, such as the Asthma Coalition, to create a resource directory for clients (not limited to mold, mites, dust, roaches, pets, etc) | | | | | | | | | | |
| **Milestone #3**<br>Develop and implement evidence-based asthma management guidelines. | | | | | | | | | | |
| **Task**<br>PPS incorporates evidence-based guidelines that are periodically evaluated and revised, if necessary, in the design and implementation of asthma management. | | | | | | | | | | |
| **Task**<br>1. Identify nationally recognized evidence based guidelines such as NHLBI and/or EPR3 for asthma management, medication management and care pathways. Additionally, coordinate efforts with the Albany Medical Center Evidenced-Based Medicine Asthma guidelines DSRIP Project already created to align common efforts where the 2 projects overlaps | | | | | | | | | | |
| **Task**<br>2. Submit clinical guideline recommendations to the Clinical Integration & Quality committee for approval | | | | | | | | | | |
| **Task**<br>3. Identify indoor trigger control guidelines from recognized entities such as the EPA and other environmental improvement agencies | | | | | | | | | | |
| **Task**<br>4. Implement adopted guidelines into participating sites and providers. | | | | | | | | | | |
| **Task**<br>5. Track and evaluate programs roll out using rapid cycle team evaluation techniques | | | | | | | | | | |
| **Task**<br>6. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | | | | | | | | | | |
| **Task**<br>7. Communicate with asthma project providers level of success of program quarterly | | | | | | | | | | |
| **Milestone #4**<br>Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans. | | | | | | | | | | |
| **Task**<br>PPS has developed training and comprehensive asthma self- | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| management education, to include basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans. | | | | | | | | | | |
| **Task** 1. Project team to evaluate and choose age appropriate education model for asthma home-based self-management. | | | | | | | | | | |
| **Task** 2. Identify and/or develop asthma education materials | | | | | | | | | | |
| **Task** 3. Ensure materials are aligned with age-appropriate culturally competency and health literacy strategy. | | | | | | | | | | |
| **Task** 4. Present training and education material recommendations to the workforce committee for integration into the learning management system (LMS) | | | | | | | | | | |
| **Task** 5. Present training and education material recommendations to the cultural competency and health literacy task force for acceptance | | | | | | | | | | |
| **Task** 6. Develop roadmap for asthma training for providers | | | | | | | | | | |
| **Task** 7. Consider training across projects to increase awareness of asthma management and triggers with all providers | | | | | | | | | | |
| **Task** 8. Include and enlist community health coaches for training sessions for continuity of education | | | | | | | | | | |
| **Task** 9. Educate school based programs on project goals and their roles (eg- American Academy of Pediatrics use and feedback, school referrals to home-based self-management, etc.) | | | | | | | | | | |
| **Task** 10. Include asthma action plan templates for home care and process to track use at home and school (including triggers) | | | | | | | | | | |
| **Task** 11. Evaluate LMS for training platform for asthma self-management and other IT training solutions. | | | | | | | | | | |
| **Task** 12. Track and evaluate programs roll out using rapid cycle team evaluation techniques | | | | | | | | | | |
| **Task** 13. Report to Clinical Integration and Quality committee quarterly | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| and revise objectives to improve outcomes when indicated | | | | | | | | | | |
| **Milestone #5** Ensure coordinated care for asthma patients includes social services and support. | | | | | | | | | | |
| **Task** PPS has developed and conducted training of all providers, including social services and support. | | | | | | | | | | |
| **Task** All practices in PPS have a Clinical Interoperability System in place for all participating providers. | | | | | | | | | | |
| **Task** PPS has assembled a care coordination team that includes use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management. | | | | | | | | | | |
| **Task** 1. Finalize Contract/MOUs with social service organizations | | | | | | | | | | |
| **Task** 2. Finalize Contract/MOUs with members of asthma care coordination team, including school nurses, pharmacists, CHW, dieticians, home care agency staff, environment agencies, state supported agencies, housing | | | | | | | | | | |
| **Task** 3. Finalize strategy for coordinating care and social services for the home-based asthma self-management program | | | | | | | | | | |
| **Task** 4. Present recommendations to the Clinical Integration and Quality committee of the PPS on project methodology | | | | | | | | | | |
| **Task** 5. Determine requirements for clinical interoperability within systems in regards to avoiding medication errors or duplicate services. | | | | | | | | | | |
| **Task** 6. Project team to work with IT to determine clinical workflow and technology tools to incorporate into this project | | | | | | | | | | |
| **Task** 7. Develop a roll-out plan for systems to achieve interoperability, including a training plan to support the successful implementation of new platforms and processes | | | | | | | | | | |
| **Task** 8. Explore education programs including learning collaborative models, regional collaborative sessions and LMS for social service providers | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task** 9. Coordinate with IT roadmap for provider Clinical Interoperability System | | | | | | | | | | |
| **Task** 10. Integrate communication avenues for medication reconciliation measures per IT roadmap | | | | | | | | | | |
| **Task** 11. Appraise the availability of providing asthma education and certification funding to social service providers and schools to improve outcomes | | | | | | | | | | |
| **Milestone #6** Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events. | | | | | | | | | | |
| **Task** Follow-up services implemented after ED or hospital visit occurs. Root cause analysis is conducted and shared with patient's family. | | | | | | | | | | |
| **Task** 1. Develop strategy for follow-up services after negative event, including consulting with partners that provide follow-up services | | | | | | | | | | |
| **Task** 2. Finalize strategy for root cause analysis and teach back to patient and/or family, with focus of use of asthma action plan | | | | | | | | | | |
| **Task** 3. Identify IT solutions for event notifications to project teams | | | | | | | | | | |
| **Task** 4. Develop plan for project overlap education to ED care navigators, hospital to home providers, care transition providers, CHW, and other providers regarding RCA process and evolvement | | | | | | | | | | |
| **Task** 5. Connect providers to RCA process and plans for provisions of feedback to avoid future events | | | | | | | | | | |
| **Task** 6. Consider creating tool for patient/family that can be used at the ED visit or post discharge from hospital as part of asthma action plan | | | | | | | | | | |
| **Task** 7. Present follow up services strategy to cultural competency & health literacy taskforce to align with overall strategies | | | | | | | | | | |
| **Task** 8. Present follow up strategy to workforce committee to use as tool to determine workforce related gap in services, if appropriate | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>9. Track and evaluate programs roll out using RCA conclusions quarterly | | | | | | | | | | |
| **Task**<br>10. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | | | | | | | | | | |
| **Task**<br>11. Consider piloting Community Emergency Management Services (EMS) program to conduct home visits for education, self-management support to improve asthma home management. Include information from EMS in home/environmental assessments | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>12. PPS will measure outcomes of the program and follow up services as determined by the Clinical Integration & Quality Committee to ensure optimal success by utilizing a continuous process improvement model. | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>13. Quarterly outcome dashboards will be developed and reported to project teams, Clinical Integration & Quality Committee and goverance committees to track program success. | | | | | | | | | | |
| **Milestone #7**<br>Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers. | | | | | | | | | | |
| **Task**<br>PPS has established agreements with MCOs that address the coverage of patients with asthma health issues. PPS has established agreements with health home care managers, PCPs, and specialty providers. | | | | | | | | | | |
| **Task**<br>1. Identify from MCO's in the region if they offer asthma at home trigger reduction programs and self-management programs | | | | | | | | | | |
| **Task**<br>2. Identify benefit offerings including covered drugs for asthma with protocols for their use | | | | | | | | | | |
| **Task**<br>3. Compare AFBHC desired guidelines with health plan offerings and establish approach to increase or change coverage if required | | | | | | | | | | |
| **Task**<br>4. Establish role of health plan, health home care managers, and primary care providers and include these roles in respective | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| provider contracts. | | | | | | | | | | |
| **Task** 5. Finalize Contract/MOUs with MCOs at PPS level, specific to coverage of asthma health issue payments | | | | | | | | | | |
| **Milestone #8** Use EHRs or other technical platforms to track all patients engaged in this project. | | | | | | | | | | |
| **Task** PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. | | | | | | | | | | |
| **Task** 1. Determine requirements for identification of targeted patients and tracking actively engaged patients per state-provided specifications for the DSRIP program. | | | | | | | | | | |
| **Task** 2. Review strategies and tools needed to promote DSRIP specific Patient Engagement | | | | | | | | | | |
| **Task** 3. Working with the project team document current and future state work flow in addition to capturing manual solutions in place at this time. | | | | | | | | | | |
| **Task** 4. Assess current EHR and other technical platforms in the PPS against established requirements for patient identification and tracking, system notification, and treatment plan creation. | | | | | | | | | | |
| **Task** 5. Create a gap analysis based on the work flow analysis to determine incremental IT needs and associated budget, including short-term manual solutions. | | | | | | | | | | |
| **Task** 6. Identify prioritization of systems to build or associated change with separate work streams focused on implementing new Electronic Health Record Systems vs. RHIO connectivity based on the project needs and associated providers' needs | | | | | | | | | | |
| **Task** 7. Develop a roll-out plan for systems to achieve clinical data sharing, including a training plan to support the successful implementation of new platforms and processes | | | | | | | | | | |
| **Task** 8. Establish a process for monitoring project milestones and performance. | | | | | | | | | | |
| **Task** 9. Where electronic functionality is not yet ready, implement alternate in the interim and track conversion to electronic | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| systems. | | | | | | | | | | |
| **Task**<br>10. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS. | | | | | | | | | | |
| **Task**<br>11. Develop a process for determining how success will be measured that incorporates feedback from practitioners and other key users of IT, including financial and patient engagement impact and risks. | | | | | | | | | | |

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Milestone #1**<br>Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up. | | | | | | | | | | |
| **Task**<br>PPS has developed a strategy for the collaboration of community medical and social services providers to assess a patient's home and provide self-management education for the appropriate control of asthma. | | | | | | | | | | |
| **Task**<br>1. Using CNA results and population health tools, hot spot asthma diagnoses in the covered 6 county region | | | | | | | | | | |
| **Task**<br>2. Develop strategy to collaborate with neighboring PPS (see # 3 below) that selected projects asthma and tobacco use cessation projects | | | | | | | | | | |
| **Task**<br>3. Identify opportunities for collaboration with neighboring PPS's such as Albany Medical Center & Adirondack Health Institute. | | | | | | | | | | |
| **Task**<br>4. Integrate project plan components with PPS projects that influence outcomes and collaborate with surrounding communities and other PPS as necessary | | | | | | | | | | |
| **Task**<br>5. Identify project lead at PPS level | | | | | | | | | | |
| **Task**<br>6. Identify those provider and/or sites, including PCPs, home care providers, health homes, pharmacies, school health and hospital that support the activities of the Asthma self-management program | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>7. Finalize Contract/MOUs with PCP practices and community providers | | | | | | | | | | |
| **Task**<br>8. Assess providers to determine current home based asthma programs, range of services provided, and referral mechanisms for identified patients. | | | | | | | | | | |
| **Task**<br>9. Examine data to identify hot spotting areas for common asthma triggers in the identified population | | | | | | | | | | |
| **Task**<br>10. Target areas for the project utilizing hot spotting and assessment. | | | | | | | | | | |
| **Task**<br>11. Phase roll-out of project plans to coincide with in place resources | | | | | | | | | | |
| **Task**<br>12. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | | | | | | | | | | |
| **Task**<br>13. Finalize strategy for expanding home-based asthma self-management program | | | | | | | | | | |
| **Task**<br>14. Implement clinical guidelines and processes | | | | | | | | | | |
| **Task**<br>15. Track and evaluate programs roll out using rapid cycle team evaluation techniques | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>16. Identify entities & agencies that will be implementing home based medical and social services, including current providers | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>17. Develop strategy with workforce team to identify gaps in needed community providers, monitor progress of filling gaps & identifying training opportunities to minimize shortages. | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Responses<br>18. Develop strategy for systematic rollout of home assessment workforce into the community to enhance home assessments & follow ups. | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>19. Develop plan for referral process from primary care & medical facilities that encounter asthma patients to community | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| medical and social service providers, including process for feedback and improvement to referring entity. | | | | | | | | | | |
| **Milestone #2**<br>Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke. | | | | | | | | | | |
| **Task**<br>PPS has developed intervention protocols and identified resources in the community to assist patients with needed evidence-based trigger reduction interventions. | | | | | | | | | | |
| **Task**<br>1. Identify project lead and clinical support team for project potentially utilizing members from the project implementation groups | | | | | | | | | | |
| **Task**<br>2. Select procedures and intervention protocols for project | | | | | | | | | | |
| **Task**<br>3. Partner with resources such as the Asthma Coalition to fill in gaps if indicated | | | | | | | | | | |
| **Task**<br>4. Present recommendations to the Clinical Integration and Quality committee of the PPS on project methodology | | | | | | | | | | |
| **Task**<br>5. Develop strategy to partner with community resources, such as pest control and housing to link clients with resources available for reducing environmental asthma triggers | | | | | | | | | | |
| **Task**<br>6. Develop plans with the tobacco cessation project (4 b i) to reduce second hand smoke as an asthma trigger and connect engaged patients and families with tobacco cessation tools and education. | | | | | | | | | | |
| **Task**<br>7. Collaborate with the cultural competency & health literacy committee to establish age appropriate, culturally sensitive interventions to engage clients | | | | | | | | | | |
| **Task**<br>8. Collaborate with the workforce committee to leverage workforce resources such as community health workers (CHW) to engage clients | | | | | | | | | | |
| **Task**<br>9. Partner with community resources, such as the Asthma Coalition, to create a resource directory for clients (not limited to mold, mites, dust, roaches, pets, etc) | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Milestone #3**<br>Develop and implement evidence-based asthma management guidelines. | | | | | | | | | | |
| **Task**<br>PPS incorporates evidence-based guidelines that are periodically evaluated and revised, if necessary, in the design and implementation of asthma management. | | | | | | | | | | |
| **Task**<br>1. Identify nationally recognized evidence based guidelines such as NHLBI and/or EPR3 for asthma management, medication management and care pathways. Additionally, coordinate efforts with the Albany Medical Center Evidenced-Based Medicine Asthma guidelines DSRIP Project already created to align common efforts where the 2 projects overlaps | | | | | | | | | | |
| **Task**<br>2. Submit clinical guideline recommendations to the Clinical Integration & Quality committee for approval | | | | | | | | | | |
| **Task**<br>3. Identify indoor trigger control guidelines from recognized entities such as the EPA and other environmental improvement agencies | | | | | | | | | | |
| **Task**<br>4. Implement adopted guidelines into participating sites and providers. | | | | | | | | | | |
| **Task**<br>5. Track and evaluate programs roll out using rapid cycle team evaluation techniques | | | | | | | | | | |
| **Task**<br>6. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | | | | | | | | | | |
| **Task**<br>7. Communicate with asthma project providers level of success of program quarterly | | | | | | | | | | |
| **Milestone #4**<br>Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans. | | | | | | | | | | |
| **Task**<br>PPS has developed training and comprehensive asthma self-management education, to include basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| action plans. | | | | | | | | | | |
| **Task** 1. Project team to evaluate and choose age appropriate education model for asthma home-based self-management. | | | | | | | | | | |
| **Task** 2. Identify and/or develop asthma education materials | | | | | | | | | | |
| **Task** 3. Ensure materials are aligned with age-appropriate culturally competency and health literacy strategy. | | | | | | | | | | |
| **Task** 4. Present training and education material recommendations to the workforce committee for integration into the learning management system (LMS) | | | | | | | | | | |
| **Task** 5. Present training and education material recommendations to the cultural competency and health literacy task force for acceptance | | | | | | | | | | |
| **Task** 6. Develop roadmap for asthma training for providers | | | | | | | | | | |
| **Task** 7. Consider training across projects to increase awareness of asthma management and triggers with all providers | | | | | | | | | | |
| **Task** 8. Include and enlist community health coaches for training sessions for continuity of education | | | | | | | | | | |
| **Task** 9. Educate school based programs on project goals and their roles (eg- American Academy of Pediatrics use and feedback, school referrals to home-based self-management, etc.) | | | | | | | | | | |
| **Task** 10. Include asthma action plan templates for home care and process to track use at home and school (including triggers) | | | | | | | | | | |
| **Task** 11. Evaluate LMS for training platform for asthma self-management and other IT training solutions. | | | | | | | | | | |
| **Task** 12. Track and evaluate programs roll out using rapid cycle team evaluation techniques | | | | | | | | | | |
| **Task** 13. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated | | | | | | | | | | |
| **Milestone #5** Ensure coordinated care for asthma patients includes social services and support. | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task** PPS has developed and conducted training of all providers, including social services and support. | | | | | | | | | | |
| **Task** All practices in PPS have a Clinical Interoperability System in place for all participating providers. | | | | | | | | | | |
| **Task** PPS has assembled a care coordination team that includes use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management. | | | | | | | | | | |
| **Task** 1. Finalize Contract/MOUs with social service organizations | | | | | | | | | | |
| **Task** 2. Finalize Contract/MOUs with members of asthma care coordination team, including school nurses, pharmacists, CHW, dieticians, home care agency staff, environment agencies, state supported agencies, housing | | | | | | | | | | |
| **Task** 3. Finalize strategy for coordinating care and social services for the home-based asthma self-management program | | | | | | | | | | |
| **Task** 4. Present recommendations to the Clinical Integration and Quality committee of the PPS on project methodology | | | | | | | | | | |
| **Task** 5. Determine requirements for clinical interoperability within systems in regards to avoiding medication errors or duplicate services. | | | | | | | | | | |
| **Task** 6. Project team to work with IT to determine clinical workflow and technology tools to incorporate into this project | | | | | | | | | | |
| **Task** 7. Develop a roll-out plan for systems to achieve interoperability, including a training plan to support the successful implementation of new platforms and processes | | | | | | | | | | |
| **Task** 8. Explore education programs including learning collaborative models, regional collaborative sessions and LMS for social service providers | | | | | | | | | | |
| **Task** 9. Coordinate with IT roadmap for provider Clinical Interoperability System | | | | | | | | | | |
| **Task** 10. Integrate communication avenues for medication | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| reconciliation measures per IT roadmap | | | | | | | | | | |
| **Task** 11. Appraise the availability of providing asthma education and certification funding to social service providers and schools to improve outcomes | | | | | | | | | | |
| **Milestone #6** Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events. | | | | | | | | | | |
| **Task** Follow-up services implemented after ED or hospital visit occurs. Root cause analysis is conducted and shared with patient's family. | | | | | | | | | | |
| **Task** 1. Develop strategy for follow-up services after negative event, including consulting with partners that provide follow-up services | | | | | | | | | | |
| **Task** 2. Finalize strategy for root cause analysis and teach back to patient and/or family, with focus of use of asthma action plan | | | | | | | | | | |
| **Task** 3. Identify IT solutions for event notifications to project teams | | | | | | | | | | |
| **Task** 4. Develop plan for project overlap education to ED care navigators, hospital to home providers, care transition providers, CHW, and other providers regarding RCA process and evolvement | | | | | | | | | | |
| **Task** 5. Connect providers to RCA process and plans for provisions of feedback to avoid future events | | | | | | | | | | |
| **Task** 6. Consider creating tool for patient/family that can be used at the ED visit or post discharge from hospital as part of asthma action plan | | | | | | | | | | |
| **Task** 7. Present follow up services strategy to cultural competency & health literacy taskforce to align with overall strategies | | | | | | | | | | |
| **Task** 8. Present follow up strategy to workforce committee to use as tool to determine workforce related gap in services, if appropriate | | | | | | | | | | |
| **Task** 9. Track and evaluate programs roll out using RCA conclusions quarterly | | | | | | | | | | |
| **Task** 10. Report to Clinical Integration and Quality committee quarterly | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| and revise objectives to improve outcomes when indicated | | | | | | | | | | |
| **Task**<br>11. Consider piloting Community Emergency Management Services (EMS) program to conduct home visits for education, self-management support to improve asthma home management. Include information from EMS in home/environmental assessments | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>12. PPS will measure outcomes of the program and follow up services as determined by the Clinical Integration & Quality Committee to ensure optimal success by utilizing a continuous process improvement model. | | | | | | | | | | |
| **Task**<br>9-24-15 Remediation Response<br>13. Quarterly outcome dashboards will be developed and reported to project teams, Clinical Integration & Quality Committee and goverance committees to track program success. | | | | | | | | | | |
| **Milestone #7**<br>Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers. | | | | | | | | | | |
| **Task**<br>PPS has established agreements with MCOs that address the coverage of patients with asthma health issues. PPS has established agreements with health home care managers, PCPs, and specialty providers. | | | | | | | | | | |
| **Task**<br>1. Identify from MCO's in the region if they offer asthma at home trigger reduction programs and self-management programs | | | | | | | | | | |
| **Task**<br>2. Identify benefit offerings including covered drugs for asthma with protocols for their use | | | | | | | | | | |
| **Task**<br>3. Compare AFBHC desired guidelines with health plan offerings and establish approach to increase or change coverage if required | | | | | | | | | | |
| **Task**<br>4. Establish role of health plan, health home care managers, and primary care providers and include these roles in respective provider contracts. | | | | | | | | | | |
| **Task**<br>5. Finalize Contract/MOUs with MCOs at PPS level, specific to coverage of asthma health issue payments | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Milestone #8** Use EHRs or other technical platforms to track all patients engaged in this project. | | | | | | | | | | |
| **Task** PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. | | | | | | | | | | |
| **Task** 1. Determine requirements for identification of targeted patients and tracking actively engaged patients per state-provided specifications for the DSRIP program. | | | | | | | | | | |
| **Task** 2. Review strategies and tools needed to promote DSRIP specific Patient Engagement | | | | | | | | | | |
| **Task** 3. Working with the project team document current and future state work flow in addition to capturing manual solutions in place at this time. | | | | | | | | | | |
| **Task** 4. Assess current EHR and other technical platforms in the PPS against established requirements for patient identification and tracking, system notification, and treatment plan creation. | | | | | | | | | | |
| **Task** 5. Create a gap analysis based on the work flow analysis to determine incremental IT needs and associated budget, including short-term manual solutions. | | | | | | | | | | |
| **Task** 6. Identify prioritization of systems to build or associated change with separate work streams focused on implementing new Electronic Health Record Systems vs. RHIO connectivity based on the project needs and associated providers' needs | | | | | | | | | | |
| **Task** 7. Develop a roll-out plan for systems to achieve clinical data sharing, including a training plan to support the successful implementation of new platforms and processes | | | | | | | | | | |
| **Task** 8. Establish a process for monitoring project milestones and performance. | | | | | | | | | | |
| **Task** 9. Where electronic functionality is not yet ready, implement alternate in the interim and track conversion to electronic systems. | | | | | | | | | | |
| **Task** 10. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS. | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>11. Develop a process for determining how success will be measured that incorporates feedback from practitioners and other key users of IT, including financial and patient engagement impact and risks. | | | | | | | | | | |

### Prescribed Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|

No Records Found

### Prescribed Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|
| Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up. | Task 7 originally dated 12/31/2015 has been moved to 6/30/2016 to reflect the ongoing nature of the work. |
| Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke. | Task 2 originally dated 12/31/2015 has been moved to 3/31/2016. Tasks 4 and 5 originally dated 12/31/2015 have been moved to 6/30/2016. These changes reflect the ongoing nature of the work. |
| Develop and implement evidence-based asthma management guidelines. | |
| Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans. | |
| Ensure coordinated care for asthma patients includes social services and support. | |
| Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events. | Task 1 originally dated 12/31/2015 has been moved to 6/30/2016. Tasks 2 and 3 originally dated 12/31/2015 have been moved to 9/30/2016. These changes reflect the ongoing nature of the work. |
| Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers. | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Prescribed Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|
| Use EHRs or other technical platforms to track all patients engaged in this project. | |

### Milestone Review Status

| Milestone # | Review Status | IA Formal Comments |
|---|---|---|
| **Milestone #1** | Pass & Ongoing | |
| **Milestone #2** | Pass & Ongoing | |
| **Milestone #3** | Pass & Ongoing | |
| **Milestone #4** | Pass & Ongoing | |
| **Milestone #5** | Pass & Ongoing | |
| **Milestone #6** | Pass & Ongoing | |
| **Milestone #7** | Pass & Ongoing | |
| **Milestone #8** | Pass & Ongoing | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 3.d.ii.4 - PPS Defined Milestones

**Instructions :**

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for PPS-defined milestones.

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|

No Records Found

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC  (PPS ID:3)

### IPQR Module 3.d.ii.5 - IA Monitoring

**Instructions :**

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Project 3.g.i – Integration of palliative care into the PCMH Model

#### IPQR Module 3.g.i.1 - Major Risks to Implementation and Mitigation Strategies

**Instructions :**

Please describe what the major risks are for this project, as well as the actions you plan to take to mitigate them.

Palliative Care is not presently a covered benefit across all providers which places this project at risk for succeeding if providers refuse to engage in unreimbursed services. To mitigate this risk, the PPS will build upon our effective partnership with MCOs in DSRIP project design to advocate for reimbursement for services required by the DSRIP projects. Success of the mitigation strategy will be seen when MCO/PPS agreements have been made.

There are many IT Risks, such as manual tracking of data, data interoperability using multiple vendors that may not support existing standards- the risk mitigation strategy is to engage vendors early & determine supplemental solutions if available. The RHIO (the expected interoperable clinical platform) has expressed limitations on data sharing per NY state policies, working with EHR vendors to achieve data sharing & balancing DSRIP needs with existing commitments. Population Health IT (PHIT) systems & tools are required & delay to PHIT implementation delays the projects & risks not meeting speed/scale requirements. PHIT depends on sufficient capital funding from NY state & delay in capital release will delay the rollout. The PPS will work with the RHIO, accelerate implementation of PHIT interoperability, use alternate methods where EHRs & PHIT tool functionality aren't ready & work with NY to ensure capital is given in sufficient time.

As care shifts to the Primary Care Provider, the AFBHC risks overwhelming providers with expectations associated with the DSRIP projects. The mitigation strategy is to bundle interventions as much as possible; to demonstrate the common links between DSRIP requirements, and to provide technical support, tools and training to practices from the PPS administrative offices. The PPS will also extend the reach of its current palliative care services to accommodate patient referrals and decrease the burden to the PCP practice.

Another risk to the successful completion of this project is that the PPS does not achieve NCQA recognition for its primary care practices by DY3, Q4. To mitigate this risk, the PPS is dedicating at least one project manager to PCMH certification as well as employing consultant team to assist practices in obtaining certification. Current state of the practices will be assessed, technical assistance needs identified and technical assistance will be provided from the PPS central project management office. Success of the mitigation strategy will be seen in number of providers achieving NCQA recognition within the targeted timeframe.

Additional risks to successful engagement of patients in palliative care services are religious and cultural beliefs about end of life for both patients/families and providers/care givers. The is also an existing misunderstanding of patients, families and providers that palliative care is applicable only for patients at the end of life and that palliative care involves doing less for the patient. The PPS mitigation strategy is to: 1) develop culturally and linguistically appropriate approaches, There staff training and patient education materials; 2) educate patients/families and providers/care givers about the differences between palliative care and hospice;

Success of the mitigation strategy will be seen in patient and provider engagement in palliative care services and referrals.

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 3.g.i.2 - Patient Engagement Speed

**Instructions :**

Enter the number of patients actively engaged through the current quarter. The number entered into the "Patient Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for DY1 Q3 should include patients previously reported in DY1 Q2 plus new patients engaged in DY1 Q3. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

| Benchmarks | |
|---|---|
| **100% Actively Engaged By** | **Expected Patient Engagement** |
| DY4,Q4 | 16,301 |

| Patients Engaged to Date in Current DY | DY1,Q3 Patient Update | % of Semi-Annual Commitment To-Date | Semi-Annual Variance of Projected to Actual | % of Total Actively Engaged Patients To-Date |
|---|---|---|---|---|
| 236 | 236 | 20.45% | 918 | 1.45% |

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (1,154)

### Current File Uploads

| User ID | File Type | File Name | File Description | Upload Date |
|---|---|---|---|---|
| cdomeier | Communication Documentation | 3_PMDL5115_1_3_20160129161221_DY1Q3_absense_of_patient_registry_explanation.docx | Explanation for absence of DY1, Q3 Patient Update | 01/29/2016 04:12 PM |

**Narrative Text :**

For PPS to provide additional context regarding progress and/or updates to IA.

### Module Review Status

| Review Status | IA Formal Comments |
|---|---|
| Fail | The PPS failed to meet at least 80% of its actively engaged commitments for DY1Q3. The documentation does not support the reported actively engaged numbers. |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 3.g.i.3 - Prescribed Milestones

**Instructions :**

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for prescribed milestones. For milestones that are due and completed within the reporting period, documentation is required to provide evidence of project requirement achievement. Any explanations regarding altered or missed provider commitments should be included within the narrative box, not as text within uploaded documentation.

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| **Milestone #1** Integrate Palliative Care into appropriate participating PCPs that have, or will have, achieved NCQA PCMH and/or APCM certification. | Project | N/A | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** PPS has identified primary care providers integrating palliative care services into their practice model. Primary care practices using PCMH and/or APCM have been included. The PPS has received agreement from those PCPs not PCMH and/or APCM certified to become certified to at least Level 1 of the 2014 NCQA PCMH and/or APCM by Demonstration Year 3. | Provider | Practitioner - Primary Care Provider (PCP) | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 1. The PPS PCMH Project Team will inventory partnering PCP practices, hospice providers, palliative care providers that will participate with integrating palliative care services into their practice model. | Project | | Completed | 04/01/2015 | 12/31/2015 | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 |
| **Task** 2. PPS Operations Team will execute contract/MOU's with participating sites, CBO's and other identified providers | Project | | In Progress | 04/01/2015 | 12/31/2015 | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task** 3. In concert with the additional projects that require PCMH certification, the PPS PCMH Project Team will establish a strategy to assist participating non-PCMH certified practices to obtain Level 3 NCQA certification who are participating in this project | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 4. The PPS will engage Project Implementation Palliative Care subject matter experts to conduct a "palliative care gap analysis" with each PCMH site, nursing home and non-PCHM practices to identified gaps in care | Project | | In Progress | 07/01/2015 | 07/31/2016 | 07/01/2015 | 07/31/2016 | 09/30/2016 | DY2 Q2 |

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## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>5. Project Implementation Group will develop a strategic plan for the PPS to create specific interventions of the identified gaps in care from the analysis | Project | | In Progress | 07/01/2015 | 01/31/2017 | 07/01/2015 | 01/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>6. PPS will conduct an assessment for the utilization of tele-medicine opportunities for palliative care consultations for participating providers sites and LTC facilities | Project | | In Progress | 09/01/2015 | 03/31/2016 | 09/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task**<br>7. The PPS will collaborate with the Workforce Committee to propose an anticipated plan to recruit, redeploy and reassign new and existing staff to support integration of palliative care services at participating sites including PCP practices, LTC facilities etc… | Project | | In Progress | 09/01/2015 | 03/31/2017 | 09/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #2**<br>Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>The PPS has developed partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the PCP practice. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>1. PPS will develop BAA's, MOUs, & provider agreements with CBO's and hospice to assist in obtaining medical provider support, Chaplain services, and enhance 24/7 on call support to create a patient centered palliative plan of care with their PCP and support services | Project | | In Progress | 07/01/2015 | 03/31/2017 | 07/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>2. In concert with the Clinical Integration Committee, the Palliative Care Project Implementation Team will propose and advise on best practice modalities to integrate Palliative Care Services and Primary Care (ie: Advance care plan using Respecting Choices http://www.gundersenhealth.org/respecting-choices ), pain & symptom management, addressing psychosocial & spiritual concerns, establishing goals of care and coordination of care. | Project | | In Progress | 09/01/2015 | 03/31/2016 | 09/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** | Project | | In Progress | 09/01/2015 | 03/31/2016 | 09/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| 3. PPS will survey participating sites to determine current state for offering/providing palliative care services and the expectation to enhance existing services | | | | | | | | | |
| **Task**<br>4. The PPS & Workforce Committee will conduct and assess the current state to determine potential workforce needs | Project | | In Progress | 10/01/2015 | 03/31/2016 | 10/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task**<br>5. The PPS will engage in opportunities to collaborative and mentor neighboring PPS and service providers in overlapping counties to coordinate physician and clinical education, adopt evidence-based practice models and build a referral process for the region | Project | | In Progress | 10/01/2015 | 12/31/2016 | 10/01/2015 | 12/31/2016 | 12/31/2016 | DY2 Q3 |
| **Task**<br>6. In conjunction with Project 2 b iv and 2 b viii, engage hospice, home care agencies and CBO's to capacitate and strengthen palliative home care for use in all disease-related discharges from the hospitals and nursing homes | Project | | In Progress | 04/01/2016 | 12/31/2016 | 04/01/2016 | 12/31/2016 | 12/31/2016 | DY2 Q3 |
| **Task**<br>7. PPS will measure outcomes as determined by the Clinical Integration and Quality Committee to ensure optimal success by utilizing the Plan – Do – Study – Act methodology | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #3**<br>Develop and adopt clinical guidelines agreed to by all partners including services and eligibility. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>PPS has developed/adopted clinical guidelines agreed to by all partners including services and eligibility, that include implementation, where appropriate, of the DOH-5003 Medical Orders for Life Sustaining Treatment (MOLST) form. PPS has trained staff addressing role-appropriate competence in palliative care skills. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>1. The Clinical Operations Team will complete a current state assessment of which PCP practices are currently utilizing the MOLST form. | Project | | In Progress | 09/01/2015 | 03/31/2016 | 09/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task**<br>2. For those participating practices that are not currently utilizing MOLST, the PPS will provide general MOLST education and | Project | | In Progress | 09/01/2015 | 03/31/2016 | 09/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| assist practices to obtain current forms to provide consistency for advance direct health planning throughout the PPS | | | | | | | | | |
| **Task** 3. Palliative Care Team in collaboration with the Clinical Integration and Quality Committee will create, adopt and disseminate clinical guidelines that assist providers and other clinically trained staff to effectively administer the DOH -5003 MOLST form for individuals that are at end of life, have serious, chronic conditions and multiple co-morbidities. | Project | | In Progress | 09/01/2015 | 03/31/2017 | 09/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 4. PPS will develop a standardized referral process for PCP sites to engaged Palliative Care consultation services. (ie: existing PC staff and/or tele-medicine) | Project | | In Progress | 11/01/2015 | 03/31/2016 | 11/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 5. Collaborate with the practitioner engagement task force and practicing sites to identify a physician and/or provider champion. | Project | | In Progress | 11/01/2015 | 09/30/2016 | 11/01/2015 | 09/30/2016 | 09/30/2016 | DY2 Q2 |
| **Task** 6. Participating PCP practices can adopt the "Fast Facts" which is a peer-reviewed, evidence-based summaries for key palliative care topics that can be utilized by providers (https://www.capc.org/fast-facts/) | Project | | In Progress | 11/01/2015 | 12/31/2016 | 11/01/2015 | 12/31/2016 | 12/31/2016 | DY2 Q3 |
| **Task** 7. With the Clinical Integration and Quality Committee, create common network triggers generated by EHRs & technical platforms to automatically alert the provider for review for appropriateness of palliative services | Project | | In Progress | 11/01/2015 | 03/31/2017 | 11/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 8. Each practice site "champion" will be paired with a Palliative Care subject matter expert and receive mentoring and education to integrate services | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 9. Provide education to key clinical integration team members embedded in Projects 2.b.iv and 2.b.viii to increase awareness of palliative care services for hospitalized patients and their families to reduce preventable readmissions. Consider performing a gap analysis of the availability of hospital based palliative care services in our PPS, optimizing availability of inpatient palliative care services to be a support intervention | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

# New York State Department Of Health
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## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>10. Collaborate with Cultural Competency and Health Literacy Taskforce to incorporate age appropriate clinical guidelines and ensure care pathways encompass patient and family cultural competency and health literacy aspects. | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #4**<br>Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>Staff has received appropriate palliative care skills training, including training on PPS care protocols. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>1. Evaluate a PPS-wide Learning Management System (LMS) and other education resources to develop and implement a standardized educational program on role appropriate palliative care skills/services and PPS adopted clinical guidelines. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>2. PPS will assist practicing PCP sites and LTC facilities to have membership access to the Center to Advance Palliative Care (CAPC) website to obtain training materials and courses for providers and clinical champions | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>3. PPS will have subject matter experts available to participating practices and LTC facilities to provide education, mentorship and preceptorship approaches to best integrate palliative care into a PCP Practice & LTC Setting | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>4. Introduce a 'train the trainer' approach through "Respecting Choices" for prompting and holding conversations leading to advance directives discussions | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>5. Palliative Care Implementation Planning team will create a variety of approaches to provide PPS education through: online CME coursework as developed by CAPC, lunch and learn sessions, external mentors for specialized workshops, & webinars. | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>6. Track training competency through LMS system | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| **Milestone #5** Engage with Medicaid Managed Care to address coverage of services. | Project | N/A | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** PPS has established agreements with MCOs that address the coverage of palliative care supports and services. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 1. Review AFBHC adopted palliative care guidelines with Medicaid and Medicare MCOs in the region. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 2. Compare AFBHC guidelines to MCOs' palliative care guidelines and benefit structure associated with Medicare Advantage (MA), Fully Integrated Duals Advantage (FIDA), Managed Long Term Care (MLTC) programs. Also compare AFBHC guidelines to FFS Medicare | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 3. Determine if needed supports and services are missing from the MCOs benefit structure and jointly present to DOH for coverage consideration and premium adjustments. | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 4. Based on conclusions from step 3, determine contracting strategy with MCOs for covered services and implications for an integrated PCMH/palliative care VBP methodology. | Project | | In Progress | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #6** Use EHRs or other IT platforms to track all patients engaged in this project. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** Step 1: Determine requirements for identification of targeted patients and tracking actively engaged patients per state-provided specifications for the DSRIP program | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** Step 2: Review strategies and tools needed to promote DSRIP specific Patient Engagement for palliative care | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** Step 3: Working with the project committee document current and future state work flow of Palliative care project in addition to | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|---|
| capturing manual solutions in place at this time. | | | | | | | | | |
| **Task** Step 4: Assess current EHR and other technical platforms in the PPS against established requirements for patient identification and tracking, system notification, and treatment plan creation. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** Step 5: Create a gap analysis based on the work flow analysis to determine incremental IT needs and associated budget, including short-term manual solutions | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** Step 6: Identify prioritization of systems to build or associated change with separate work streams focused on implementing new Electronic Health Record Systems vs. RHIO connectivity based on the DSRIP project needs and associated providers' needs | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** Step 7: Develop a roll-out plan for systems to achieve clinical data sharing, including a training plan to support the successful implementation of new platforms and processes | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** Step 8: Establish a process for monitoring project milestones and performance | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** Step 9: Where electronic functionality is not yet ready, implement alternate in the interim and track conversion to electronic systems | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** Step 10: Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** Step 11: Develop a process for determining how success will be measured that incorporates feedback from practitioners and other key users of IT, including financial and patient engagement impact and risks. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Milestone #1** | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| Integrate Palliative Care into appropriate participating PCPs that have, or will have, achieved NCQA PCMH and/or APCM certification. | | | | | | | | | | |
| **Task**<br>PPS has identified primary care providers integrating palliative care services into their practice model. Primary care practices using PCMH and/or APCM have been included. The PPS has received agreement from those PCPs not PCMH and/or APCM certified to become certified to at least Level 1 of the 2014 NCQA PCMH and/or APCM by Demonstration Year 3. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 61 | 142 | 243 |
| **Task**<br>1. The PPS PCMH Project Team will inventory partnering PCP practices, hospice providers, palliative care providers that will participate with integrating palliative care services into their practice model. | | | | | | | | | | |
| **Task**<br>2. PPS Operations Team will execute contract/MOU's with participating sites, CBO's and other identified providers | | | | | | | | | | |
| **Task**<br>3. In concert with the additional projects that require PCMH certification, the PPS PCMH Project Team will establish a strategy to assist participating non-PCMH certified practices to obtain Level 3 NCQA certification who are participating in this project | | | | | | | | | | |
| **Task**<br>4. The PPS will engage Project Implementation Palliative Care subject matter experts to conduct a "palliative care gap analysis" with each PCMH site, nursing home and non-PCHM practices to identified gaps in care | | | | | | | | | | |
| **Task**<br>5. Project Implementation Group will develop a strategic plan for the PPS to create specific interventions of the identified gaps in care from the analysis | | | | | | | | | | |
| **Task**<br>6. PPS will conduct an assessment for the utilization of tele-medicine opportunities for palliative care consultations for participating providers sites and LTC facilities | | | | | | | | | | |
| **Task**<br>7. The PPS will collaborate with the Workforce Committee to propose an anticipated plan to recruit, redeploy and reassign new and existing staff to support integration of palliative care services at participating sites including PCP practices, LTC facilities etc… | | | | | | | | | | |
| **Milestone #2** | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice. | | | | | | | | | | |
| **Task**<br>The PPS has developed partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the PCP practice. | | | | | | | | | | |
| **Task**<br>1. PPS will develop BAA's, MOUs, & provider agreements with CBO's and hospice to assist in obtaining medical provider support, Chaplain services, and enhance 24/7 on call support to create a patient centered palliative plan of care with their PCP and support services | | | | | | | | | | |
| **Task**<br>2. In concert with the Clinical Integration Committee, the Palliative Care Project Implementation Team will propose and advise on best practice modalities to integrate Palliative Care Services and Primary Care (ie: Advance care plan using Respecting Choices http://www.gundersenhealth.org/respecting-choices ), pain & symptom management, addressing psychosocial & spiritual concerns, establishing goals of care and coordination of care. | | | | | | | | | | |
| **Task**<br>3. PPS will survey participating sites to determine current state for offering/providing palliative care services and the expectation to enhance existing services | | | | | | | | | | |
| **Task**<br>4. The PPS & Workforce Committee will conduct and assess the current state to determine potential workforce needs | | | | | | | | | | |
| **Task**<br>5. The PPS will engage in opportunities to collaborative and mentor neighboring PPS and service providers in overlapping counties to coordinate physician and clinical education, adopt evidence-based practice models and build a referral process for the region | | | | | | | | | | |
| **Task**<br>6. In conjunction with Project 2 b iv and 2 b viii, engage hospice, home care agencies and CBO's to capacitate and strengthen palliative home care for use in all disease-related discharges from the hospitals and nursing homes | | | | | | | | | | |
| **Task**<br>7. PPS will measure outcomes as determined by the Clinical Integration and Quality Committee to ensure optimal success by utilizing the Plan – Do – Study – Act methodology | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Milestone #3**<br>Develop and adopt clinical guidelines agreed to by all partners including services and eligibility. | | | | | | | | | | |
| **Task**<br>PPS has developed/adopted clinical guidelines agreed to by all partners including services and eligibility, that include implementation, where appropriate, of the DOH-5003 Medical Orders for Life Sustaining Treatment (MOLST) form. PPS has trained staff addressing role-appropriate competence in palliative care skills. | | | | | | | | | | |
| **Task**<br>1. The Clinical Operations Team will complete a current state assessment of which PCP practices are currently utilizing the MOLST form. | | | | | | | | | | |
| **Task**<br>2. For those participating practices that are not currently utilizing MOLST, the PPS will provide general MOLST education and assist practices to obtain current forms to provide consistency for advance direct health planning throughout the PPS | | | | | | | | | | |
| **Task**<br>3. Palliative Care Team in collaboration with the Clinical Integration and Quality Committee will create, adopt and disseminate clinical guidelines that assist providers and other clinically trained staff to effectively administer the DOH -5003 MOLST form for individuals that are at end of life, have serious, chronic conditions and multiple co-morbidities. | | | | | | | | | | |
| **Task**<br>4. PPS will develop a standardized referral process for PCP sites to engaged Palliative Care consultation services. (ie: existing PC staff and/or tele-medicine) | | | | | | | | | | |
| **Task**<br>5. Collaborate with the practitioner engagement task force and practicing sites to identify a physician and/or provider champion. | | | | | | | | | | |
| **Task**<br>6. Participating PCP practices can adopt the "Fast Facts" which is a peer-reviewed, evidence-based summaries for key palliative care topics that can be utilized by providers (https://www.capc.org/fast-facts/) | | | | | | | | | | |
| **Task**<br>7. With the Clinical Integration and Quality Committee, create common network triggers generated by EHRs & technical platforms to automatically alert the provider for review for appropriateness of palliative services | | | | | | | | | | |
| **Task**<br>8. Each practice site "champion" will be paired with a Palliative | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| Care subject matter expert and receive mentoring and education to integrate services | | | | | | | | | | |
| **Task**<br>9. Provide education to key clinical integration team members embedded in Projects 2.b.iv and 2.b.viii to increase awareness of palliative care services for hospitalized patients and their families to reduce preventable readmissions. Consider performing a gap analysis of the availability of hospital based palliative care services in our PPS, optimizing availability of inpatient palliative care services to be a support intervention | | | | | | | | | | |
| **Task**<br>10. Collaborate with Cultural Competency and Health Literacy Taskforce to incorporate age appropriate clinical guidelines and ensure care pathways encompass patient and family cultural competency and health literacy aspects. | | | | | | | | | | |
| **Milestone #4**<br>Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS. | | | | | | | | | | |
| **Task**<br>Staff has received appropriate palliative care skills training, including training on PPS care protocols. | | | | | | | | | | |
| **Task**<br>1. Evaluate a PPS-wide Learning Management System (LMS) and other education resources to develop and implement a standardized educational program on role appropriate palliative care skills/services and PPS adopted clinical guidelines. | | | | | | | | | | |
| **Task**<br>2. PPS will assist practicing PCP sites and LTC facilities to have membership access to the Center to Advance Palliative Care (CAPC) website to obtain training materials and courses for providers and clinical champions | | | | | | | | | | |
| **Task**<br>3. PPS will have subject matter experts available to participating practices and LTC facilities to provide education, mentorship and preceptorship approaches to best integrate palliative care into a PCP Practice & LTC Setting | | | | | | | | | | |
| **Task**<br>4. Introduce a 'train the trainer' approach through "Respecting Choices" for prompting and holding conversations leading to advance directives discussions | | | | | | | | | | |
| **Task**<br>5. Palliative Care Implementation Planning team will create a variety of approaches to provide PPS education through: online CME coursework as developed by CAPC, lunch and learn | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| sessions, external mentors for specialized workshops, & webinars. | | | | | | | | | | |
| **Task**<br>6. Track training competency through LMS system | | | | | | | | | | |
| **Milestone #5**<br>Engage with Medicaid Managed Care to address coverage of services. | | | | | | | | | | |
| **Task**<br>PPS has established agreements with MCOs that address the coverage of palliative care supports and services. | | | | | | | | | | |
| **Task**<br>1. Review AFBHC adopted palliative care guidelines with Medicaid and Medicare MCOs in the region. | | | | | | | | | | |
| **Task**<br>2. Compare AFBHC guidelines to MCOs' palliative care guidelines and benefit structure associated with Medicare Advantage (MA), Fully Integrated Duals Advantage (FIDA), Managed Long Term Care (MLTC) programs. Also compare AFBHC guidelines to FFS Medicare | | | | | | | | | | |
| **Task**<br>3. Determine if needed supports and services are missing from the MCOs benefit structure and jointly present to DOH for coverage consideration and premium adjustments. | | | | | | | | | | |
| **Task**<br>4. Based on conclusions from step 3, determine contracting strategy with MCOs for covered services and implications for an integrated PCMH/palliative care VBP methodology. | | | | | | | | | | |
| **Milestone #6**<br>Use EHRs or other IT platforms to track all patients engaged in this project. | | | | | | | | | | |
| **Task**<br>PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. | | | | | | | | | | |
| **Task**<br>Step 1: Determine requirements for identification of targeted patients and tracking actively engaged patients per state-provided specifications for the DSRIP program | | | | | | | | | | |
| **Task**<br>Step 2: Review strategies and tools needed to promote DSRIP specific Patient Engagement for palliative care | | | | | | | | | | |
| **Task**<br>Step 3: Working with the project committee document current and future state work flow of Palliative care project in addition to capturing manual solutions in place at this time. | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task** Step 4: Assess current EHR and other technical platforms in the PPS against established requirements for patient identification and tracking, system notification, and treatment plan creation. | | | | | | | | | | |
| **Task** Step 5: Create a gap analysis based on the work flow analysis to determine incremental IT needs and associated budget, including short-term manual solutions | | | | | | | | | | |
| **Task** Step 6: Identify prioritization of systems to build or associated change with separate work streams focused on implementing new Electronic Health Record Systems vs. RHIO connectivity based on the DSRIP project needs and associated providers' needs | | | | | | | | | | |
| **Task** Step 7: Develop a roll-out plan for systems to achieve clinical data sharing, including a training plan to support the successful implementation of new platforms and processes | | | | | | | | | | |
| **Task** Step 8: Establish a process for monitoring project milestones and performance | | | | | | | | | | |
| **Task** Step 9: Where electronic functionality is not yet ready, implement alternate in the interim and track conversion to electronic systems | | | | | | | | | | |
| **Task** Step 10: Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS | | | | | | | | | | |
| **Task** Step 11: Develop a process for determining how success will be measured that incorporates feedback from practitioners and other key users of IT, including financial and patient engagement impact and risks. | | | | | | | | | | |

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Milestone #1** Integrate Palliative Care into appropriate participating PCPs that have, or will have, achieved NCQA PCMH and/or APCM certification. | | | | | | | | | | |
| **Task** PPS has identified primary care providers integrating palliative care services into their practice model. Primary care practices using PCMH and/or APCM have been included. The PPS has | 364 | 506 | 506 | 506 | 506 | 506 | 506 | 506 | 506 | 506 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| received agreement from those PCPs not PCMH and/or APCM certified to become certified to at least Level 1 of the 2014 NCQA PCMH and/or APCM by Demonstration Year 3. | | | | | | | | | | |
| **Task**<br>1. The PPS PCMH Project Team will inventory partnering PCP practices, hospice providers, palliative care providers that will participate with integrating palliative care services into their practice model. | | | | | | | | | | |
| **Task**<br>2. PPS Operations Team will execute contract/MOU's with participating sites, CBO's and other identified providers | | | | | | | | | | |
| **Task**<br>3. In concert with the additional projects that require PCMH certification, the PPS PCMH Project Team will establish a strategy to assist participating non-PCMH certified practices to obtain Level 3 NCQA certification who are participating in this project | | | | | | | | | | |
| **Task**<br>4. The PPS will engage Project Implementation Palliative Care subject matter experts to conduct a "palliative care gap analysis" with each PCMH site, nursing home and non-PCHM practices to identified gaps in care | | | | | | | | | | |
| **Task**<br>5. Project Implementation Group will develop a strategic plan for the PPS to create specific interventions of the identified gaps in care from the analysis | | | | | | | | | | |
| **Task**<br>6. PPS will conduct an assessment for the utilization of tele-medicine opportunities for palliative care consultations for participating providers sites and LTC facilities | | | | | | | | | | |
| **Task**<br>7. The PPS will collaborate with the Workforce Committee to propose an anticipated plan to recruit, redeploy and reassign new and existing staff to support integration of palliative care services at participating sites including PCP practices, LTC facilities etc… | | | | | | | | | | |
| **Milestone #2**<br>Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice. | | | | | | | | | | |
| **Task**<br>The PPS has developed partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the PCP practice. | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>1. PPS will develop BAA's, MOUs, & provider agreements with CBO's and hospice to assist in obtaining medical provider support, Chaplain services, and enhance 24/7 on call support to create a patient centered palliative plan of care with their PCP and support services | | | | | | | | | | |
| **Task**<br>2. In concert with the Clinical Integration Committee, the Palliative Care Project Implementation Team will propose and advise on best practice modalities to integrate Palliative Care Services and Primary Care (ie: Advance care plan using Respecting Choices http://www.gundersenhealth.org/respecting-choices ), pain & symptom management, addressing psychosocial & spiritual concerns, establishing goals of care and coordination of care. | | | | | | | | | | |
| **Task**<br>3. PPS will survey participating sites to determine current state for offering/providing palliative care services and the expectation to enhance existing services | | | | | | | | | | |
| **Task**<br>4. The PPS & Workforce Committee will conduct and assess the current state to determine potential workforce needs | | | | | | | | | | |
| **Task**<br>5. The PPS will engage in opportunities to collaborative and mentor neighboring PPS and service providers in overlapping counties to coordinate physician and clinical education, adopt evidence-based practice models and build a referral process for the region | | | | | | | | | | |
| **Task**<br>6. In conjunction with Project 2 b iv and 2 b viii, engage hospice, home care agencies and CBO's to capacitate and strengthen palliative home care for use in all disease-related discharges from the hospitals and nursing homes | | | | | | | | | | |
| **Task**<br>7. PPS will measure outcomes as determined by the Clinical Integration and Quality Committee to ensure optimal success by utilizing the Plan – Do – Study – Act methodology | | | | | | | | | | |
| **Milestone #3**<br>Develop and adopt clinical guidelines agreed to by all partners including services and eligibility. | | | | | | | | | | |
| **Task**<br>PPS has developed/adopted clinical guidelines agreed to by all partners including services and eligibility, that include implementation, where appropriate, of the DOH-5003 Medical | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| Orders for Life Sustaining Treatment (MOLST) form. PPS has trained staff addressing role-appropriate competence in palliative care skills. | | | | | | | | | | |
| **Task**<br>1. The Clinical Operations Team will complete a current state assessment of which PCP practices are currently utilizing the MOLST form. | | | | | | | | | | |
| **Task**<br>2. For those participating practices that are not currently utilizing MOLST, the PPS will provide general MOLST education and assist practices to obtain current forms to provide consistency for advance direct health planning throughout the PPS | | | | | | | | | | |
| **Task**<br>3. Palliative Care Team in collaboration with the Clinical Integration and Quality Committee will create, adopt and disseminate clinical guidelines that assist providers and other clinically trained staff to effectively administer the DOH -5003 MOLST form for individuals that are at end of life, have serious, chronic conditions and multiple co-morbidities. | | | | | | | | | | |
| **Task**<br>4. PPS will develop a standardized referral process for PCP sites to engaged Palliative Care consultation services. (ie: existing PC staff and/or tele-medicine) | | | | | | | | | | |
| **Task**<br>5. Collaborate with the practitioner engagement task force and practicing sites to identify a physician and/or provider champion. | | | | | | | | | | |
| **Task**<br>6. Participating PCP practices can adopt the "Fast Facts" which is a peer-reviewed, evidence-based summaries for key palliative care topics that can be utilized by providers (https://www.capc.org/fast-facts/) | | | | | | | | | | |
| **Task**<br>7. With the Clinical Integration and Quality Committee, create common network triggers generated by EHRs & technical platforms to automatically alert the provider for review for appropriateness of palliative services | | | | | | | | | | |
| **Task**<br>8. Each practice site "champion" will be paired with a Palliative Care subject matter expert and receive mentoring and education to integrate services | | | | | | | | | | |
| **Task**<br>9. Provide education to key clinical integration team members embedded in Projects 2.b.iv and 2.b.viii to increase awareness of palliative care services for hospitalized patients and their families to reduce preventable readmissions. Consider performing a gap | | | | | | | | | | |

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| analysis of the availability of hospital based palliative care services in our PPS, optimizing availability of inpatient palliative care services to be a support intervention | | | | | | | | | | |
| **Task**<br>10. Collaborate with Cultural Competency and Health Literacy Taskforce to incorporate age appropriate clinical guidelines and ensure care pathways encompass patient and family cultural competency and health literacy aspects. | | | | | | | | | | |
| **Milestone #4**<br>Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS. | | | | | | | | | | |
| **Task**<br>Staff has received appropriate palliative care skills training, including training on PPS care protocols. | | | | | | | | | | |
| **Task**<br>1. Evaluate a PPS-wide Learning Management System (LMS) and other education resources to develop and implement a standardized educational program on role appropriate palliative care skills/services and PPS adopted clinical guidelines. | | | | | | | | | | |
| **Task**<br>2. PPS will assist practicing PCP sites and LTC facilities to have membership access to the Center to Advance Palliative Care (CAPC) website to obtain training materials and courses for providers and clinical champions | | | | | | | | | | |
| **Task**<br>3. PPS will have subject matter experts available to participating practices and LTC facilities to provide education, mentorship and preceptorship approaches to best integrate palliative care into a PCP Practice & LTC Setting | | | | | | | | | | |
| **Task**<br>4. Introduce a 'train the trainer' approach through "Respecting Choices" for prompting and holding conversations leading to advance directives discussions | | | | | | | | | | |
| **Task**<br>5. Palliative Care Implementation Planning team will create a variety of approaches to provide PPS education through: online CME coursework as developed by CAPC, lunch and learn sessions, external mentors for specialized workshops, & webinars. | | | | | | | | | | |
| **Task**<br>6. Track training competency through LMS system | | | | | | | | | | |
| **Milestone #5**<br>Engage with Medicaid Managed Care to address coverage of services. | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>PPS has established agreements with MCOs that address the coverage of palliative care supports and services. | | | | | | | | | | |
| **Task**<br>1. Review AFBHC adopted palliative care guidelines with Medicaid and Medicare MCOs in the region. | | | | | | | | | | |
| **Task**<br>2. Compare AFBHC guidelines to MCOs' palliative care guidelines and benefit structure associated with Medicare Advantage (MA), Fully Integrated Duals Advantage (FIDA), Managed Long Term Care (MLTC) programs. Also compare AFBHC guidelines to FFS Medicare | | | | | | | | | | |
| **Task**<br>3. Determine if needed supports and services are missing from the MCOs benefit structure and jointly present to DOH for coverage consideration and premium adjustments. | | | | | | | | | | |
| **Task**<br>4. Based on conclusions from step 3, determine contracting strategy with MCOs for covered services and implications for an integrated PCMH/palliative care VBP methodology. | | | | | | | | | | |
| **Milestone #6**<br>Use EHRs or other IT platforms to track all patients engaged in this project. | | | | | | | | | | |
| **Task**<br>PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. | | | | | | | | | | |
| **Task**<br>Step 1: Determine requirements for identification of targeted patients and tracking actively engaged patients per state-provided specifications for the DSRIP program | | | | | | | | | | |
| **Task**<br>Step 2: Review strategies and tools needed to promote DSRIP specific Patient Engagement for palliative care | | | | | | | | | | |
| **Task**<br>Step 3: Working with the project committee document current and future state work flow of Palliative care project in addition to capturing manual solutions in place at this time. | | | | | | | | | | |
| **Task**<br>Step 4: Assess current EHR and other technical platforms in the PPS against established requirements for patient identification and tracking, system notification, and treatment plan creation. | | | | | | | | | | |
| **Task**<br>Step 5: Create a gap analysis based on the work flow analysis to determine incremental IT needs and associated budget, including short-term manual solutions | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task** Step 6: Identify prioritization of systems to build or associated change with separate work streams focused on implementing new Electronic Health Record Systems vs. RHIO connectivity based on the DSRIP project needs and associated providers' needs | | | | | | | | | | |
| **Task** Step 7: Develop a roll-out plan for systems to achieve clinical data sharing, including a training plan to support the successful implementation of new platforms and processes | | | | | | | | | | |
| **Task** Step 8: Establish a process for monitoring project milestones and performance | | | | | | | | | | |
| **Task** Step 9: Where electronic functionality is not yet ready, implement alternate in the interim and track conversion to electronic systems | | | | | | | | | | |
| **Task** Step 10: Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS | | | | | | | | | | |
| **Task** Step 11: Develop a process for determining how success will be measured that incorporates feedback from practitioners and other key users of IT, including financial and patient engagement impact and risks. | | | | | | | | | | |

### Prescribed Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|

No Records Found

### Prescribed Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|
| Integrate Palliative Care into appropriate participating PCPs that have, or will have, achieved NCQA PCMH and/or APCM certification. | Task 2 originally dated 12/31/2015 has been moved to 6/30/2016 to reflect the ongoing nature of the work. |
| Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice. | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Prescribed Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|
| Develop and adopt clinical guidelines agreed to by all partners including services and eligibility. | |
| Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS. | |
| Engage with Medicaid Managed Care to address coverage of services. | |
| Use EHRs or other IT platforms to track all patients engaged in this project. | |

### Milestone Review Status

| Milestone # | Review Status | IA Formal Comments |
|---|---|---|
| **Milestone #1** | Pass & Ongoing | |
| **Milestone #2** | Pass & Ongoing | |
| **Milestone #3** | Pass & Ongoing | |
| **Milestone #4** | Pass & Ongoing | |
| **Milestone #5** | Pass & Ongoing | |
| **Milestone #6** | Pass & Ongoing | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 3.g.i.4 - PPS Defined Milestones

**Instructions :**

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for PPS-defined milestones.

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|

No Records Found

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC  (PPS ID:3)

### IPQR Module 3.g.i.5 - IA Monitoring

**Instructions :**

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Project 4.a.iii – Strengthen Mental Health and Substance Abuse Infrastructure across Systems

#### IPQR Module 4.a.iii.1 - Major Risks to Implementation and Mitigation Strategies

**Instructions :**

Please describe what the major risks are for this project, as well as the actions you plan to take to mitigate them.

An identified risk to this Domain 4 project is low provider participation for a variety of factors which could negatively impact the success of this project. One risk to the project would be low provider participation due to lack of reimbursement for meetings, workgroups, sessions and general time commitments of the providers. Through the PPS governance and workforce committees, this risk will be minimized by tracking provider engagement quarterly , partnering with behavioral health, substance abuse centers and community organizations to access changes in participation from current state to future state. An effort will be made to launch the screenings in all collaborative care sites and those providers willing to partner as a first step; then bring on other providers. In conjunction with the other behavioral health projects engaged by the AFBHC PPS, such as 3 a iv, providers will be educated on mental health issues and concerns in the catchment area, and sessions will be tracked through community based partnerships. Success will be measured by an increase in the use of the unified screening tool for patients accessing services of the PPS providers.

There is always the possibility that outlier providers not in the PPS network will interact with patients from the PPS network. The formation of a MEB taskforce by end of DY1, Collaborative Care Model provider champions determined by end of DY1 and work with the Clinical Integration and Quality Committee to develop standards and best practice guidelines will be shared with regularly scheduled meetings of neighboring PPS's, focusing on common projects to mitigate redundancies and identify specific collaborative opportunities, such as this project and others. Specifically, this project can effectively decrease the risk of a missed opportunity for screening these patients by incorporating the MEB tool into the projects within the PPS and sharing this tool as a collaborative means with other PPS in the area so incorporation of the tool can also be done at various sites. The AFBHC will build upon the expertise and experience of providers already using screenings to identify patient risk levels and will create replicable models for the delivery of screenings.
Interoperability of current state IT capabilities and the possibility that all participants will not be on a similar IT platform is a risk to the successful attainment of health care transition with this project. Successful partnership with the IT component of the PPS, evaluating current state of providers and plans to build and/or level resources will be necessary to ensure success. The AFBHC will work with IT in the development of embedded screening tools in EHRs with clinical prompts, especially related to specific diagnostic dyads of diabetes/depression and psychosis/substance use. Alternative methods to tracking and completing survey may have to be implemented, such as paper, data entry into dashboards, utilizing resources, until interoperability is obtained.

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 4.a.iii.2 - PPS Defined Milestones

**Instructions :**

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for PPS-defined milestones.

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|
| **Milestone** Participate in MEB health promotion and MEB disorder prevention partnerships. | In Progress | Participate in MEB health promotion and MEB disorder prevention partnerships. | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 1. Engage partnering providers to utilize the Adverse Childhood Experiences (ACE) tool to assess member's risk factors of illness and death and improve our efforts towards prevention and recovery. | In Progress | 1. Engage partnering providers to utilize the Adverse Childhood Experiences (ACE) tool to assess member's risk factors of illness and death and improve our efforts towards prevention and recovery. | 09/01/2015 | 03/31/2016 | 09/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 2. Implement the Collaborative Prevention Model for individuals at moderate or high risk of poor health outcomes | In Progress | 2. Implement the Collaborative Prevention Model for individuals at moderate or high risk of poor health outcomes | 09/01/2015 | 03/31/2016 | 09/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 3. Develop a MEB taskforce to train participating providers and other health professionals in MEB health promotion & MEB disorder prevention by developing a trauma informed care approach using the prevention agenda strategies, goals and objectives. https://www.health.ny.gov/prevention/prevention_agenda/mental_health_and_substance_abuse | In Progress | 3. Develop a MEB taskforce to train participating providers and other health professionals in MEB health promotion & MEB disorder prevention by developing a trauma informed care approach using the prevention agenda strategies, goals and objectives. https://www.health.ny.gov/prevention/prevention_agenda/mental_health_and_substance_abuse | 09/01/2015 | 03/31/2016 | 09/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** 4. Engage multi-levels of community agencies and established taskforces to become members of the MEB taskforce to create a trauma-informed culture for care, to encourage MEB health promotion (by local government units, public health, prevention | In Progress | 4. Engage multi-levels of community agencies and established taskforces to become members of the MEB taskforce to create a trauma-informed culture for care, to encourage MEB health promotion (by local government units, public health, prevention specialist/educators, etc.) | 09/01/2015 | 03/31/2016 | 09/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|
| specialist/educators, etc.) | | | | | | | | |
| **Task**<br>5. Assess and collaborate with IT using a screening kiosk for members where results are electronically populated in an EHR for provider access | In Progress | 5. Assess and collaborate with IT using a screening kiosk for members where results are electronically populated in an EHR for provider access | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>6. Target populations into segments for achievement: community-settings on regional basis focusing on low income hotspots and on areas with highest behavioral health morbidity | In Progress | 6. Target populations into segments for achievement: community-settings on regional basis focusing on low income hotspots and on areas with highest behavioral health morbidity | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Milestone**<br>Expand efforts with DOH and OMH to implement 'Collaborative Care' in primary care settings throughout NYS. | In Progress | Expand efforts with DOH and OMH to implement 'Collaborative Care' in primary care settings throughout NYS. | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>1. Collaborate with our participating providers of physical health care to increase access to screening MEB conditions. | In Progress | 1. Collaborate with our participating providers of physical health care to increase access to screening MEB conditions. | 09/01/2015 | 03/31/2016 | 09/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task**<br>2. Integrate physical health MEB screenings into behavioral health outpatient setting in collaboration with the 3 a i project work group | In Progress | 2. Integrate physical health MEB screenings into behavioral health outpatient setting in collaboration with the 3 a i project work group | 09/01/2015 | 03/31/2018 | 09/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>3. Develop cohesive team approach to integrate standardized, evidence based screening tools into care delivery | In Progress | 3. Develop cohesive team approach to integrate standardized, evidence based screening tools into care delivery | 09/01/2015 | 03/31/2016 | 09/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task**<br>4. Utilize funding for the MEB taskforce to purchase evidence-based screening tools & provide education in various settings to our providers. | In Progress | 4. Utilize funding for the MEB taskforce to purchase evidence-based screening tools & provide education in various settings to our providers. | 09/01/2015 | 03/31/2018 | 09/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>5. Provide prevention/education via trauma informed care approach to members according to risk. Develop and utilize prevention curriculum to improve protective factors and | In Progress | 5. Provide prevention/education via trauma informed care approach to members according to risk. Develop and utilize prevention curriculum to improve protective factors and reduce risk | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|
| reduce risk | | | | | | | | |
| **Task**<br>6. Create a Collaborative Care Model in identified Primary Care and Behavioral Health practices | In Progress | 6. Create a Collaborative Care Model in identified Primary Care and Behavioral Health practices | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Milestone**<br>Provide cultural and linguistic training on MEB health promotion, prevention and treatment. | In Progress | Provide cultural and linguistic training on MEB health promotion, prevention and treatment. | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>1. Collaborate with SUNY Buffalo Institute of Trauma and the project sub-committee of 3 a i, to develop web-based, care training modules that can be accessed at various sites. | In Progress | 1. Collaborate with SUNY Buffalo Institute of Trauma and the project sub-committee of 3 a i, to develop web-based, care training modules that can be accessed at various sites. | 09/01/2015 | 03/31/2017 | 09/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>2. Create educational programs that are gender and culturally specific in regards to trauma assessment and care | In Progress | 2. Create educational programs that are gender and culturally specific in regards to trauma assessment and care | 09/01/2015 | 03/31/2017 | 09/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>3. Link to PPS Cultural Competency initiative with focus on culture of poverty as it relates to trauma exposure and social living circumstances. | In Progress | 3. Link to PPS Cultural Competency initiative with focus on culture of poverty as it relates to trauma exposure and social living circumstances. | 01/01/2016 | 03/31/2017 | 01/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>4. Through identified hot spots in our regional community needs assessment, develop outreach screening forums to community settings linked to low income populations & homelessness. | In Progress | 4. Through identified hot spots in our regional community needs assessment, develop outreach screening forums to community settings linked to low income populations & homelessness. | 01/01/2016 | 03/31/2018 | 01/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>9-24-15 Remediation Response<br>5. PPS will measure outcomes of the program as determined by the Clinical Integration and Quality Committe to ensure optimal success by utilizing a continuous process improvement method. | In Progress | 9-24-15 Remediation Response<br>5. PPS will measure outcomes of the program as determined by the Clinical Integration and Quality Committe to ensure optimal success by utilizing a continuous process improvement method. | 09/24/2015 | 03/31/2017 | 09/24/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task**<br>9-24-15 Remediation Response | In Progress | 9-24-15 Remediation Response<br>6. Quarterly outcome dashboards measuring certain metrics and | 09/24/2015 | 03/31/2017 | 09/24/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|
| 6. Quarterly outcome dashboards measuring certain metrics and consumer engagement results will be developed and reported to project teams, Clinical Integration and Quality committee and governance committees to track outcomes including satisfaction levels and adjust program methods, if required | | consumer engagement results will be developed and reported to project teams, Clinical Integration and Quality committee and governance committees to track outcomes including satisfaction levels and adjust program methods, if required | | | | | | |
| **Milestone**<br>Share data and information on MEB health promotion and MEB disorder prevention and treatment. | In Progress | Share data and information on MEB health promotion and MEB disorder prevention and treatment. | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>1. Develop in concert with IT consultants, a longitudinal tracking of claims data for those who have participated in prevention/education services that can be shared with providers | In Progress | 1. Develop in concert with IT consultants, a longitudinal tracking of claims data for those who have participated in prevention/education services that can be shared with providers | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>2. Explore the ability of population health databases populations to assess effectiveness of prevention education for various subpopulations | In Progress | 2. Explore the ability of population health databases populations to assess effectiveness of prevention education for various subpopulations | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>3. Collaborate with community leaders, state agencies, service providers, insurers and CBO's to form an interdisciplinary team whose responsibilities are to prioritize needs related to data, training, technical assistance and evidence-based protocols necessary to support MEB health promotion. | In Progress | 3. Collaborate with community leaders, state agencies, service providers, insurers and CBO's to form an interdisciplinary team whose responsibilities are to prioritize needs related to data, training, technical assistance and evidence-based protocols necessary to support MEB health promotion. | 09/01/2016 | 03/31/2017 | 09/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

## PPS Defined Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|

No Records Found

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### PPS Defined Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|
| Participate in MEB health promotion and MEB disorder prevention partnerships. | |
| Expand efforts with DOH and OMH to implement 'Collaborative Care' in primary care settings throughout NYS. | |
| Provide cultural and linguistic training on MEB health promotion, prevention and treatment. | |
| Share data and information on MEB health promotion and MEB disorder prevention and treatment. | |

### Module Review Status

| Review Status | IA Formal Comments |
|---|---|
| Pass & Ongoing | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC  (PPS ID:3)

### IPQR Module 4.a.iii.3 - IA Monitoring

**Instructions :**

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Project 4.b.i – Promote tobacco use cessation, especially among low SES populations and those with poor mental health.

#### IPQR Module 4.b.i.1 - Major Risks to Implementation and Mitigation Strategies

**Instructions :**

Please describe what the major risks are for this project, as well as the actions you plan to take to mitigate them.

There are a number of inherent risks associated with the promotion of tobacco use cessation, especially among low SES populations and those with poor mental health. One risk is the potential for missed opportunities for patient screening and referral. The AFBHC and the AFBHC Team has already assembled a wide array of project partners from social service agencies, including St Peter's Center for Smoking Cessation, the Tobacco-Free Coalition, and the community resource Advancing Tobacco-Free Communities of Hamilton, Fulton and Montgomery Counties. The agencies and others will continue to promote tobacco use cessation for the population that they interact with. These teams are targeting community settings for patient identification and engagement. The goals of these organizations have and will remain high reaching, with success measured in their ability to connect with the population and measure success.
With the formation of the AFBHC, the communication and marketing strategies will be to integrate tobacco use cessation into its public focused outreach as a means to keep the population aware and engaged in the need to promote a smoke free environment. This is also a perfect opportunity for the PPS to collaborate with other projects within the DSRIP plan, such as with Project 2.b.iii. to ensure smoking status is communicated to primary care provider and Patient Navigator in ED Triage project process through a screening tool on health assessment. When identified, patients will be referred and connected with smoking cessation services along care continuum, tracked and measured for compliance and recidivism. Another avenue to evaluate the tobacco using population is through the 3 d ii project, linking tobacco use to environmental triggers. This can bolster outreach efforts by linking patients and/or home trigger tobacco users to the appropriate provider/CBO.
As there can be community inertia regarding smoking as the behavior is embedded in the local culture, the AFBHC will clinically integrate tobacco use cessation throughout the projects, engage champions at multiple levels, continue to promote smoke free environments and measure success as the community's health improves with an integrated and unified approach, not just in independent silos of improvement.

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### IPQR Module 4.b.i.2 - PPS Defined Milestones

**Instructions :**

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for PPS-defined milestones.

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|
| **Milestone**<br>Adopt tobacco-free outdoor policies. | In Progress | Adopt tobacco-free outdoor policies. | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>1. The PPS will collaborate with partners and community leaders to revise tobacco free policies to include E-cigarettes | In Progress | 1. The PPS will collaborate with partners and community leaders to revise tobacco free policies to include E-cigarettes | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>2. Identify partnering sites within our communities, Advancing Tobacco Free Community contractors and with cross-county *independent PPS', that have existing tobacco free grounds—utilize existing strategies to become a "tobacco free campus" by engaging sites that serve our members, who currently do not have policies in place, to consider this initiative and decrease exposure to second hand smoke and promote reduction or eradication of current tobacco users. http://www.cdc.gov/nccdphp/dnpao/hwi/toolkits/tobacco/planning.htm *Albany Medical Center PPS, Leatherstocking & AHI PPS' | In Progress | 2. Identify partnering sites within our communities, Advancing Tobacco Free Community contractors and with cross-county *independent PPS', that have existing tobacco free grounds—utilize existing strategies to become a "tobacco free campus" by engaging sites that serve our members, who currently do not have policies in place, to consider this initiative and decrease exposure to second hand smoke and promote reduction or eradication of current tobacco users. http://www.cdc.gov/nccdphp/dnpao/hwi/toolkits/tobacco/planning.htm *Albany Medical Center PPS, Leatherstocking & AHI PPS' | 09/01/2015 | 03/31/2016 | 09/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task**<br>3. PPS Tobacco Project Team will offer smoking cessation services and referral resources to sites that will begin transformation to a tobacco-free outdoor policy. Support efforts to decrease stigmatization, foster an atmosphere to assist staff and customers to quit, improve overall | In Progress | 3. PPS Tobacco Project Team will offer smoking cessation services and referral resources to sites that will begin transformation to a tobacco-free outdoor policy. Support efforts to decrease stigmatization, foster an atmosphere to assist staff and customers to quit, improve overall community health and wellbeing while reducing healthcare tobacco related costs. | 09/01/2015 | 03/31/2018 | 09/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|
| community health and wellbeing while reducing healthcare tobacco related costs. | | | | | | | | |
| **Task** 4. The PPS, in collaboration with other community mental health providers and cross-county PPS's develop a Health Promotion and Wellness program targeting individuals with psychiatric illnesses to live a pro-health, positive image lifestyle. | In Progress | 4. The PPS, in collaboration with other community mental health providers and cross-county PPS's develop a Health Promotion and Wellness program targeting individuals with psychiatric illnesses to live a pro-health, positive image lifestyle. | 09/01/2015 | 03/31/2018 | 09/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 5. Through the Behavioral Health for Tobacco Free Living – contract with Behavioral Health providers to support this initiative & help create a culture of a tobacco free environment | In Progress | 5. Through the Behavioral Health for Tobacco Free Living – contract with Behavioral Health providers to support this initiative & help create a culture of a tobacco free environment | 09/01/2015 | 03/31/2018 | 09/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 6. Engage PPS and partnering executive leadership along with political community support to establish partnerships with identified sites to advance the transformation of a tobacco–free outdoor policy throughout all our communities and discuss additional strategies to address in-door, smoke-free housing where applicable. | In Progress | 6. Engage PPS and partnering executive leadership along with political community support to establish partnerships with identified sites to advance the transformation of a tobacco–free outdoor policy throughout all our communities and discuss additional strategies to address in-door, smoke-free housing where applicable. | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Milestone** Implement the US Public Health Services Guidelines for Treating Tobacco Use. | In Progress | Implement the US Public Health Services Guidelines for Treating Tobacco Use. | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 1. Identify participating providers and/or sites that are currently PCMH certified, where the USPHS Guidelines are already embedded. | In Progress | 1. Identify participating providers and/or sites that are currently PCMH certified, where the USPHS Guidelines are already embedded. | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 2. The AFBHC Leadership will develop strategies and timelines to assist non-PCMH providers to obtain certification | In Progress | 2. The AFBHC Leadership will develop strategies and timelines to assist non-PCMH providers to obtain certification | 09/01/2015 | 03/31/2018 | 09/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 3. Partner with 4 a iii sub-committee to develop and provide community and | In Progress | 3. Partner with 4 a iii sub-committee to develop and provide community and healthcare education on tobacco cessation strategies | 09/01/2015 | 03/31/2018 | 09/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|
| healthcare education on tobacco cessation strategies | | | | | | | | |
| **Task** 4. Tobacco Project Team will make recommendations to the Clinical Integration & Quality committee to review USPHS guidelines and develop methods to track outcomes and quality indications to ensure success. | In Progress | 4. Tobacco Project Team will make recommendations to the Clinical Integration & Quality committee to review USPHS guidelines and develop methods to track outcomes and quality indications to ensure success. | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 5. Engage IT to assist not only with reporting but to standardize tobacco use assessments on the EHR | In Progress | 5. Engage IT to assist not only with reporting but to standardize tobacco use assessments on the EHR | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Milestone** Use electronic medical records to prompt providers to complete 5 A's (Ask, Assess, Advise, Assist, and Arrange). | In Progress | Use electronic medical records to prompt providers to complete 5 A's (Ask, Assess, Advise, Assist, and Arrange). | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 1. To assess every patient, collaborate with IT to standardize the 5 A's and vital signs screening tool in the EHR. | In Progress | 1. To assess every patient, collaborate with IT to standardize the 5 A's and vital signs screening tool in the EHR. | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 2. Collaborate with IT to develop electronic reminder flags/prompts for providers to follow up (either in person or by phone) during the initial period of the treatment plan | In Progress | 2. Collaborate with IT to develop electronic reminder flags/prompts for providers to follow up (either in person or by phone) during the initial period of the treatment plan | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 3. Provide 5 A training to our PPS healthcare providers that includes adherence with USPHS clinical guidelines through counseling, prescription and over the counter treatment options, and referrals to cessation services | In Progress | 3. Provide 5 A training to our PPS healthcare providers that includes adherence with USPHS clinical guidelines through counseling, prescription and over the counter treatment options, and referrals to cessation services | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** 4. Develop a roll-out plan for PPS, including a training plan to support the successful implementation of change requests and processes | In Progress | 4. Develop a roll-out plan for PPS, including a training plan to support the successful implementation of change requests and processes | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|
| **Task**<br>5. Review, revise and align policies, procedures and guidelines for completing the 5 A's across the PPS. | In Progress | 5. Review, revise and align policies, procedures and guidelines for completing the 5 A's across the PPS. | 04/01/2015 | 03/31/2017 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone**<br>Facilitate referrals to the NYS Smokers' Quitline. | In Progress | Facilitate referrals to the NYS Smokers' Quitline. | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>1. Adopt the Opt-to-Quit™ Model to enhance triggers for the referral process and links tobacco using members to the evidence-based services of the New York State Smokers' Quitline. | In Progress | 1. Adopt the Opt-to-Quit™ Model to enhance triggers for the referral process and links tobacco using members to the evidence-based services of the New York State Smokers' Quitline. | 09/01/2015 | 03/31/2018 | 09/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>2. Collaborate with IT (and NYS Smokers' Quitline IT staff) to address system to system communication. | In Progress | 2. Collaborate with IT (and NYS Smokers' Quitline IT staff) to address system to system communication. | 11/01/2015 | 03/31/2018 | 11/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>3. Bridge gaps among our PPS healthcare providers and health delivery systems to address tobacco use at each visit with tobacco using members. | In Progress | 3. Bridge gaps among our PPS healthcare providers and health delivery systems to address tobacco use at each visit with tobacco using members. | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>4. Tobacco Project Team will coordinate PPS partnering sites to provide education to staff, administrators and practitioners to promote familiarity in addressing smoke cessation to expand the initiative to other DSRIP Projects. | In Progress | 4. Tobacco Project Team will coordinate PPS partnering sites to provide education to staff, administrators and practitioners to promote familiarity in addressing smoke cessation to expand the initiative to other DSRIP Projects. | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Milestone**<br>Increase Medicaid and other health plan coverage of tobacco dependence treatment counseling and medications. | In Progress | Increase Medicaid and other health plan coverage of tobacco dependence treatment counseling and medications. | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>1. Meet with health plans to review the use of Medicaid pharmaceutical and counseling smoking cessation benefits and guidelines and compare to DOH and CDC guidelines | In Progress | 1. Meet with health plans to review the use of Medicaid pharmaceutical and counseling smoking cessation benefits and guidelines and compare to DOH and CDC guidelines | 04/01/2016 | 03/31/2017 | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|
| **Task** 2. Evaluate benefit use rates by diagnosis and age. Segment population by diagnostic grouping and use rates | In Progress | 2. Evaluate benefit use rates by diagnosis and age. Segment population by diagnostic grouping and use rates | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 3. Evaluate results of the Medicaid Incentives for the Prevention of Chronic Disease (MIPCD) awarded to DOH by CMS for years 2011-2016 and consider using a like incentive program for the uptake of smoking cessation benefits if considered to be beneficial | In Progress | 3. Evaluate results of the Medicaid Incentives for the Prevention of Chronic Disease (MIPCD) awarded to DOH by CMS for years 2011-2016 and consider using a like incentive program for the uptake of smoking cessation benefits if considered to be beneficial | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 4. Monitor uptake performance and smoking incidence over time, adapt strategy using PDCA approach | In Progress | 4. Monitor uptake performance and smoking incidence over time, adapt strategy using PDCA approach | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Milestone** Promote smoking cessation benefits among Medicaid providers. | In Progress | Promote smoking cessation benefits among Medicaid providers. | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 1. Educate providers on the current state of coverage that beneficiaries do have for smoking cessation treatment counseling and products via variety of online, webinars, and other venues | In Progress | 1. Educate providers on the current state of coverage that beneficiaries do have for smoking cessation treatment counseling and products via variety of online, webinars, and other venues | 10/01/2015 | 03/31/2018 | 10/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 2. Through the Clinical Integration & Quality Committee, develop policies within the PPS that ensures tobacco status is queried and treatment support/counseling is documented | In Progress | 2. Through the Clinical Integration & Quality Committee, develop policies within the PPS that ensures tobacco status is queried and treatment support/counseling is documented | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 3. Provide quality monitoring feedback to providers on their performance of tobacco screening and treatment. | In Progress | 3. Provide quality monitoring feedback to providers on their performance of tobacco screening and treatment. | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** 4. Enhance connectivity for provider collaboration among medical and psychiatry during smoking cessation treatment to closely | In Progress | 4. Enhance connectivity for provider collaboration among medical and psychiatry during smoking cessation treatment to closely monitor actions or side effects of co-morbid conditions or medications. Collaborative with 3 a i Project Team. | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Milestone/Task Name | Status | Description | Original Start Date | Original End Date | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|
| monitor actions or side effects of co-morbid conditions or medications. Collaborative with 3 a i Project Team. | | | | | | | | |
| **Task**<br>5. In collaboration with health plans, appropriate practitioner types, CBOs, and state health agencies develop specific strategies to increase benefit use rate by population segments that underutilize services | In Progress | 5. In collaboration with health plans, appropriate practitioner types, CBOs, and state health agencies develop specific strategies to increase benefit use rate by population segments that underutilize services | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Milestone**<br>Create universal, consistent health insurance benefits for prescription and over-the-counter cessation medications. | In Progress | Create universal, consistent health insurance benefits for prescription and over-the-counter cessation medications. | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>1. Use findings from milestone 5 and evaluate consistency of prescription and over the counter cessation medications among health plan in the region; compare to DOH and CDC smoking cessation policies | In Progress | 1. Use findings from milestone 5 and evaluate consistency of prescription and over the counter cessation medications among health plan in the region; compare to DOH and CDC smoking cessation policies | 04/01/2016 | 03/31/2018 | 04/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Milestone**<br>Promote cessation counseling among all smokers, including people with disabilities. | In Progress | Promote cessation counseling among all smokers, including people with disabilities. | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>1. Collaborate with, cross-county independent PPS', disability advocacy groups, community support organizations and associations to create a systemic approach in planning, educating and promoting healthy behaviors | In Progress | 1. Collaborate with, cross-county independent PPS', disability advocacy groups, community support organizations and associations to create a systemic approach in planning, educating and promoting healthy behaviors | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task**<br>2. Tobacco Project Team develops self-help materials that are tailored to specific audiences that are culturally & linguistically appropriate to enhance smoker's acceptance of treatment. | In Progress | 2. Tobacco Project Team develops self-help materials that are tailored to specific audiences that are culturally & linguistically appropriate to enhance smoker's acceptance of treatment. | 04/01/2015 | 03/31/2018 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### PPS Defined Milestones Current File Uploads

| Milestone Name | User ID | File Type | File Name | Description | Upload Date |
|---|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|
| Adopt tobacco-free outdoor policies. | |
| Implement the US Public Health Services Guidelines for Treating Tobacco Use. | |
| Use electronic medical records to prompt providers to complete 5 A's (Ask, Assess, Advise, Assist, and Arrange). | |
| Facilitate referrals to the NYS Smokers' Quitline. | |
| Increase Medicaid and other health plan coverage of tobacco dependence treatment counseling and medications. | |
| Promote smoking cessation benefits among Medicaid providers. | |
| Create universal, consistent health insurance benefits for prescription and over-the-counter cessation medications. | |
| Promote cessation counseling among all smokers, including people with disabilities. | |

### Module Review Status

| Review Status | IA Formal Comments |
|---|---|
| Pass & Ongoing | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC  (PPS ID:3)

### IPQR Module 4.b.i.3 - IA Monitoring

**Instructions :**

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

### Attestation

**The Lead Representative has been designated by the Primary Lead PPS Provider (PPS Lead Entity) as the signing officiate for the DSRIP Quarterly Report. The Lead Representative has the authority to complete this attestation on behalf of the PPS network. The Lead Representative and PPS Lead Entity are responsible for the authenticity and accuracy of the material submitted in this report.**

**The Lead Representative of the Performing Provider System (PPS) must complete this attestation form in order for the project application to be accepted by the NYS Department of Health. Once the attestation is complete, the Quarterly Report will be locked down from any further editing. Do not complete this section until the entire Quarterly Report is complete.**

**If the Quarterly Report becomes locked in error and additional changes are necessary, please use the contact information on the Home Page to request that the Quarterly Report be unlocked.**

To electronically sign this Quarterly Report, please enter the required information and check the box below:

☐ **I here by attest, as the Lead Representative of the 'Alliance for Better Health Care, LLC ', that all information provided on this Quarterly report is true and accurate to the best of my knowledge, and that, following initial submission in the current quarterly reporting period as defined by NY DOH, changes made to this report were pursuant only to documented instructions or documented approval of changes from DOH or DSRIP Independent Assessor.**

| | |
|---|---|
| **Primary Lead PPS Provider:** | ELLIS HOSPITAL |
| **Secondary Lead PPS Provider:** | ST PETERS HOSPITAL ALBANY |
| **Lead Representative:** | Bethany Panzirer gilboard |
| **Submission Date:** | 03/16/2016 05:15 PM |

| | |
|---|---|
| **Comments:** | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC  (PPS ID:3)

| Status Log | | | | |
|---|---|---|---|---|
| **Quarterly Report (DY,Q)** | **Status** | **Lead Representative Name** | **User ID** | **Date Timestamp** |
| DY1, Q3 | Adjudicated | Bethany Panzirer gilboard | emcgill | 03/31/2016 05:16 PM |
| DY1, Q3 | Submitted | Bethany Panzirer gilboard | cpoe2008 | 03/16/2016 05:15 PM |
| DY1, Q3 | Returned | Bethany Panzirer gilboard | emcgill | 03/01/2016 05:12 PM |
| DY1, Q3 | Submitted | Bethany Panzirer gilboard | cpoe2008 | 02/02/2016 04:41 PM |
| DY1, Q3 | Submitted | Bethany Panzirer gilboard | cpoe2008 | 02/02/2016 04:41 PM |
| DY1, Q3 | In Process | | ETL | 01/03/2016 08:01 PM |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC  (PPS ID:3)

| Comments Log | | | |
|---|---|---|---|
| **Status** | **Comments** | **User ID** | **Date Timestamp** |
| Adjudicated | The IA has adjudicated the DY1 Q3 Quarterly Report. | emcgill | 03/31/2016 05:16 PM |
| Returned | The IA is returning the DY1Q3 Quarterly Report to the PPS for Remediation. | emcgill | 03/01/2016 05:12 PM |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Section | Module Name | Status |
|---|---|---|
| Section 01 | IPQR Module 1.1 - PPS Budget Report (Baseline) | Completed |
| | IPQR Module 1.2 - PPS Budget Report (Quarterly) | Completed |
| | IPQR Module 1.3 - PPS Flow of Funds (Baseline) | Completed |
| | IPQR Module 1.4 - PPS Flow of Funds (Quarterly) | Completed |
| | IPQR Module 1.5 - Prescribed Milestones | Completed |
| | IPQR Module 1.6 - PPS Defined Milestones | Completed |
| | IPQR Module 1.7 - IA Monitoring | |
| Section 02 | IPQR Module 2.1 - Prescribed Milestones | Completed |
| | IPQR Module 2.2 - PPS Defined Milestones | Completed |
| | IPQR Module 2.3 - Major Risks to Implementation & Risk Mitigation Strategies | Completed |
| | IPQR Module 2.4 - Major Dependencies on Organizational Workstreams | Completed |
| | IPQR Module 2.5 - Roles and Responsibilities | Completed |
| | IPQR Module 2.6 - Key Stakeholders | Completed |
| | IPQR Module 2.7 - IT Expectations | Completed |
| | IPQR Module 2.8 - Progress Reporting | Completed |
| | IPQR Module 2.9 - IA Monitoring | |
| Section 03 | IPQR Module 3.1 - Prescribed Milestones | Completed |
| | IPQR Module 3.2 - PPS Defined Milestones | Completed |
| | IPQR Module 3.3 - Major Risks to Implementation & Risk Mitigation Strategies | Completed |
| | IPQR Module 3.4 - Major Dependencies on Organizational Workstreams | Completed |
| | IPQR Module 3.5 - Roles and Responsibilities | Completed |
| | IPQR Module 3.6 - Key Stakeholders | Completed |
| | IPQR Module 3.7 - IT Expectations | Completed |
| | IPQR Module 3.8 - Progress Reporting | Completed |
| | IPQR Module 3.9 - IA Monitoring | |
| Section 04 | IPQR Module 4.1 - Prescribed Milestones | Completed |
| | IPQR Module 4.2 - PPS Defined Milestones | Completed |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Section | Module Name | Status |
|---|---|---|
| | IPQR Module 4.3 - Major Risks to Implementation & Risk Mitigation Strategies | Completed |
| | IPQR Module 4.4 - Major Dependencies on Organizational Workstreams | Completed |
| | IPQR Module 4.5 - Roles and Responsibilities | Completed |
| | IPQR Module 4.6 - Key Stakeholders | Completed |
| | IPQR Module 4.7 - IT Expectations | Completed |
| | IPQR Module 4.8 - Progress Reporting | Completed |
| | IPQR Module 4.9 - IA Monitoring | |
| Section 05 | IPQR Module 5.1 - Prescribed Milestones | Completed |
| | IPQR Module 5.2 - PPS Defined Milestones | Completed |
| | IPQR Module 5.3 - Major Risks to Implementation & Risk Mitigation Strategies | Completed |
| | IPQR Module 5.4 - Major Dependencies on Organizational Workstreams | Completed |
| | IPQR Module 5.5 - Roles and Responsibilities | Completed |
| | IPQR Module 5.6 - Key Stakeholders | Completed |
| | IPQR Module 5.7 - Progress Reporting | Completed |
| | IPQR Module 5.8 - IA Monitoring | |
| Section 06 | IPQR Module 6.1 - Prescribed Milestones | Completed |
| | IPQR Module 6.2 - PPS Defined Milestones | Completed |
| | IPQR Module 6.3 - Major Risks to Implementation & Risk Mitigation Strategies | Completed |
| | IPQR Module 6.4 - Major Dependencies on Organizational Workstreams | Completed |
| | IPQR Module 6.5 - Roles and Responsibilities | Completed |
| | IPQR Module 6.6 - Key Stakeholders | Completed |
| | IPQR Module 6.7 - IT Expectations | Completed |
| | IPQR Module 6.8 - Progress Reporting | Completed |
| | IPQR Module 6.9 - IA Monitoring | |
| Section 07 | IPQR Module 7.1 - Prescribed Milestones | Completed |
| | IPQR Module 7.2 - PPS Defined Milestones | Completed |
| | IPQR Module 7.3 - Major Risks to Implementation & Risk Mitigation Strategies | Completed |
| | IPQR Module 7.4 - Major Dependencies on Organizational Workstreams | Completed |
| | IPQR Module 7.5 - Roles and Responsibilities | Completed |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Section | Module Name | Status |
|---|---|---|
| | IPQR Module 7.6 - Key Stakeholders | Completed |
| | IPQR Module 7.7 - IT Expectations | Completed |
| | IPQR Module 7.8 - Progress Reporting | Completed |
| | IPQR Module 7.9 - IA Monitoring | |
| Section 08 | IPQR Module 8.1 - Prescribed Milestones | Completed |
| | IPQR Module 8.2 - PPS Defined Milestones | Completed |
| | IPQR Module 8.3 - Major Risks to Implementation & Risk Mitigation Strategies | Completed |
| | IPQR Module 8.4 - Major Dependencies on Organizational Workstreams | Completed |
| | IPQR Module 8.5 - Roles and Responsibilities | Completed |
| | IPQR Module 8.6 - Key Stakeholders | Completed |
| | IPQR Module 8.7 - IT Expectations | Completed |
| | IPQR Module 8.8 - Progress Reporting | Completed |
| | IPQR Module 8.9 - IA Monitoring | |
| Section 09 | IPQR Module 9.1 - Prescribed Milestones | Completed |
| | IPQR Module 9.2 - PPS Defined Milestones | Completed |
| | IPQR Module 9.3 - Major Risks to Implementation & Risk Mitigation Strategies | Completed |
| | IPQR Module 9.4 - Major Dependencies on Organizational Workstreams | Completed |
| | IPQR Module 9.5 - Roles and Responsibilities | Completed |
| | IPQR Module 9.6 - Key Stakeholders | Completed |
| | IPQR Module 9.7 - IT Expectations | Completed |
| | IPQR Module 9.8 - Progress Reporting | Completed |
| | IPQR Module 9.9 - IA Monitoring | |
| Section 10 | IPQR Module 10.1 - Overall approach to implementation | Completed |
| | IPQR Module 10.2 - Major dependencies between work streams and coordination of projects | Completed |
| | IPQR Module 10.3 - Project Roles and Responsibilities | Completed |
| | IPQR Module 10.4 - Overview of key stakeholders and how influenced by your DSRIP projects | Completed |
| | IPQR Module 10.5 - IT Requirements | Completed |
| | IPQR Module 10.6 - Performance Monitoring | Completed |
| | IPQR Module 10.7 - Community Engagement | Completed |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Section | Module Name | Status |
|---|---|---|
| | IPQR Module 10.8 - IA Monitoring | |
| Section 11 | IPQR Module 11.1 - Workforce Strategy Spending | Completed |
| | IPQR Module 11.2 - Prescribed Milestones | Completed |
| | IPQR Module 11.3 - PPS Defined Milestones | Completed |
| | IPQR Module 11.4 - Major Risks to Implementation & Risk Mitigation Strategies | Completed |
| | IPQR Module 11.5 - Major Dependencies on Organizational Workstreams | Completed |
| | IPQR Module 11.6 - Roles and Responsibilities | Completed |
| | IPQR Module 11.7 - Key Stakeholders | Completed |
| | IPQR Module 11.8 - IT Expectations | Completed |
| | IPQR Module 11.9 - Progress Reporting | Completed |
| | IPQR Module 11.10 - Staff Impact | Completed |
| | IPQR Module 11.11 - IA Monitoring | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project ID | Module Name | Status |
|---|---|---|
| 2.a.i | IPQR Module 2.a.i.1 - Major Risks to Implementation and Mitigation Strategies | Completed |
| | IPQR Module 2.a.i.2 - Prescribed Milestones | Completed |
| | IPQR Module 2.a.i.3 - PPS Defined Milestones | Completed |
| | IPQR Module 2.a.i.4 - IA Monitoring | |
| 2.b.iii | IPQR Module 2.b.iii.1 - Major Risks to Implementation and Mitigation Strategies | Completed |
| | IPQR Module 2.b.iii.2 - Patient Engagement Speed | Completed |
| | IPQR Module 2.b.iii.3 - Prescribed Milestones | Completed |
| | IPQR Module 2.b.iii.4 - PPS Defined Milestones | Completed |
| | IPQR Module 2.b.iii.5 - IA Monitoring | |
| 2.b.iv | IPQR Module 2.b.iv.1 - Major Risks to Implementation and Mitigation Strategies | Completed |
| | IPQR Module 2.b.iv.2 - Patient Engagement Speed | Completed |
| | IPQR Module 2.b.iv.3 - Prescribed Milestones | Completed |
| | IPQR Module 2.b.iv.4 - PPS Defined Milestones | Completed |
| | IPQR Module 2.b.iv.5 - IA Monitoring | |
| 2.b.viii | IPQR Module 2.b.viii.1 - Major Risks to Implementation and Mitigation Strategies | Completed |
| | IPQR Module 2.b.viii.2 - Patient Engagement Speed | Completed |
| | IPQR Module 2.b.viii.3 - Prescribed Milestones | Completed |
| | IPQR Module 2.b.viii.4 - PPS Defined Milestones | Completed |
| | IPQR Module 2.b.viii.5 - IA Monitoring | |
| 2.d.i | IPQR Module 2.d.i.1 - Major Risks to Implementation and Mitigation Strategies | Completed |
| | IPQR Module 2.d.i.2 - Patient Engagement Speed | Completed |
| | IPQR Module 2.d.i.3 - Prescribed Milestones | Completed |
| | IPQR Module 2.d.i.4 - PPS Defined Milestones | Completed |
| | IPQR Module 2.d.i.5 - IA Monitoring | |
| 3.a.i | IPQR Module 3.a.i.1 - Major Risks to Implementation and Mitigation Strategies | Completed |
| | IPQR Module 3.a.i.2 - Patient Engagement Speed | Completed |
| | IPQR Module 3.a.i.3 - Prescribed Milestones | Completed |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Project ID | Module Name | Status |
|---|---|---|
| | IPQR Module 3.a.i.4 - PPS Defined Milestones | Completed |
| | IPQR Module 3.a.i.5 - IA Monitoring | |
| 3.a.iv | IPQR Module 3.a.iv.1 - Major Risks to Implementation and Mitigation Strategies | Completed |
| | IPQR Module 3.a.iv.2 - Patient Engagement Speed | Completed |
| | IPQR Module 3.a.iv.3 - Prescribed Milestones | Completed |
| | IPQR Module 3.a.iv.4 - PPS Defined Milestones | Completed |
| | IPQR Module 3.a.iv.5 - IA Monitoring | |
| 3.d.ii | IPQR Module 3.d.ii.1 - Major Risks to Implementation and Mitigation Strategies | Completed |
| | IPQR Module 3.d.ii.2 - Patient Engagement Speed | Completed |
| | IPQR Module 3.d.ii.3 - Prescribed Milestones | Completed |
| | IPQR Module 3.d.ii.4 - PPS Defined Milestones | Completed |
| | IPQR Module 3.d.ii.5 - IA Monitoring | |
| 3.g.i | IPQR Module 3.g.i.1 - Major Risks to Implementation and Mitigation Strategies | Completed |
| | IPQR Module 3.g.i.2 - Patient Engagement Speed | Completed |
| | IPQR Module 3.g.i.3 - Prescribed Milestones | Completed |
| | IPQR Module 3.g.i.4 - PPS Defined Milestones | Completed |
| | IPQR Module 3.g.i.5 - IA Monitoring | |
| 4.a.iii | IPQR Module 4.a.iii.1 - Major Risks to Implementation and Mitigation Strategies | Completed |
| | IPQR Module 4.a.iii.2 - PPS Defined Milestones | Completed |
| | IPQR Module 4.a.iii.3 - IA Monitoring | |
| 4.b.i | IPQR Module 4.b.i.1 - Major Risks to Implementation and Mitigation Strategies | Completed |
| | IPQR Module 4.b.i.2 - PPS Defined Milestones | Completed |
| | IPQR Module 4.b.i.3 - IA Monitoring | |

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

## DSRIP Implementation Plan Project

## Alliance for Better Health Care, LLC (PPS ID:3)

| Section | Module Name / Milestone # | Review Status | |
|---|---|---|---|
| Section 01 | Module 1.1 - PPS Budget Report (Baseline) | Pass & Complete | |
| | Module 1.2 - PPS Budget Report (Quarterly) | Pass & Ongoing | |
| | Module 1.3 - PPS Flow of Funds (Baseline) | Pass & Complete | |
| | Module 1.4 - PPS Flow of Funds (Quarterly) | Pass (with Exception) & Ongoing | |
| | Module 1.5 - Prescribed Milestones | | |
| | Milestone #1 Complete funds flow budget and distribution plan and communicate with network | Pass & Ongoing | |
| Section 02 | Module 2.1 - Prescribed Milestones | | |
| | Milestone #1 Finalize governance structure and sub-committee structure | Pass (with Exception) & Complete | |
| | Milestone #2 Establish a clinical governance structure, including clinical quality committees for each DSRIP project | Pass & Complete | |
| | Milestone #3 Finalize bylaws and policies or Committee Guidelines where applicable | Pass & Complete | |
| | Milestone #4 Establish governance structure reporting and monitoring processes | Pass & Complete | |
| | Milestone #5 Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement) | Pass & Complete | |
| | Milestone #6 Finalize partnership agreements or contracts with CBOs | Pass & Ongoing | |
| | Milestone #7 Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.) | Pass & Ongoing | |
| | Milestone #8 Finalize workforce communication and engagement plan | Pass & Ongoing | |
| | Milestone #9 Inclusion of CBOs in PPS Implementation. | Pass & Complete | |
| Section 03 | Module 3.1 - Prescribed Milestones | | |
| | Milestone #1 Finalize PPS finance structure, including reporting structure | Pass & Complete | |
| | Milestone #2 Perform network financial health current state assessment and develop financial sustainability strategy to address key issues. | Pass & Ongoing | |
| | Milestone #3 Finalize Compliance Plan consistent with New York State Social Services Law 363-d | Pass & Complete | |
| | Milestone #4 Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy. | Pass & Ongoing | |
| | Milestone #5 Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the | Pass & Ongoing | |

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| Section | Module Name / Milestone # | Review Status | |
|---|---|---|---|
| | latest | | |
| | Milestone #6 Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation | Pass & Ongoing | |
| | Milestone #7 Contract 50% of care-costs through Level 1 VBPs, and >= 30% of these costs through Level 2 VBPs or higher | Pass & Ongoing | |
| | Milestone #8 >=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and >= 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher | Pass & Ongoing | |
| Section 04 | Module 4.1 - Prescribed Milestones | | |
| | Milestone #1 Finalize cultural competency / health literacy strategy. | Pass & Complete | |
| | Milestone #2 Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material). | Pass & Ongoing | |
| Section 05 | Module 5.1 - Prescribed Milestones | | |
| | Milestone #1 Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s). | Pass & Ongoing | |
| | Milestone #2 Develop an IT Change Management Strategy. | Pass & Ongoing | |
| | Milestone #3 Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network | Pass & Ongoing | |
| | Milestone #4 Develop a specific plan for engaging attributed members in Qualifying Entities | Pass & Ongoing | |
| | Milestone #5 Develop a data security and confidentiality plan. | Pass & Ongoing | |
| Section 06 | Module 6.1 - Prescribed Milestones | | |
| | Milestone #1 Establish reporting structure for PPS-wide performance reporting and communication. | Pass & Ongoing | |
| | Milestone #2 Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting. | Pass & Ongoing | |
| Section 07 | Module 7.1 - Prescribed Milestones | | |
| | Milestone #1 Develop Practitioners communication and engagement plan. | Pass & Complete | |
| | Milestone #2 Develop training / education plan targeting practioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda. | Pass & Ongoing | |
| Section 08 | Module 8.1 - Prescribed Milestones | | |
| | Milestone #1 Develop population health management roadmap. | Pass & Ongoing | |
| | Milestone #2 Finalize PPS-wide bed reduction plan. | Pass & Ongoing | |
| Section 09 | Module 9.1 - Prescribed Milestones | | |

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|---|---|---|---|
| | Milestone #1 Perform a clinical integration 'needs assessment'. | Pass & Ongoing | |
| | Milestone #2 Develop a Clinical Integration strategy. | Pass & Ongoing | |
| Section 11 | Module 11.2 - Prescribed Milestones | | |
| | Milestone #1 Define target workforce state (in line with DSRIP program's goals). | Pass & Ongoing | |
| | Milestone #2 Create a workforce transition roadmap for achieving defined target workforce state. | Pass & Ongoing | |
| | Milestone #3 Perform detailed gap analysis between current state assessment of workforce and projected future state. | Pass & Ongoing | |
| | Milestone #4 Produce a compensation and benefit analysis, covering impacts on both retrained and redeployed staff, as well as new hires, particularly focusing on full and partial placements. | Pass & Ongoing | |
| | Milestone #5 Develop training strategy. | Pass & Ongoing | |

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|---|---|---|---|
| 2.a.i | Module 2.a.i.2 - Prescribed Milestones | | |
| | 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. | Pass & Ongoing | |
| | Milestone #2 Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS. | Pass & Ongoing | |
| | 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. | Pass & Ongoing | |
| | 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. | Pass & Ongoing | |
| | 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. | Pass & Ongoing | |
| | Milestone #6 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers. | Pass & Ongoing | |
| | Milestone #7 Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3. | Pass & Ongoing | |
| | Milestone #8 Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements. | Pass & Ongoing | |
| | Milestone #9 Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform. | Pass & Ongoing | |
| | Milestone #10 Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes. | Pass & Ongoing | |
| | Milestone #11 Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate. | Pass & Ongoing | |
| 2.b.iii | Module 2.b.iii.2 - Patient Engagement Speed | Fail | |
| | Module 2.b.iii.3 - Prescribed Milestones | | |
| | Milestone #1 Establish ED care triage program for at-risk populations | Pass & Ongoing | |
| | Milestone #2 Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling.<br>a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3.<br>b. Develop process and procedures to establish connectivity between the emergency department and community primary | Pass & Ongoing | |

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| | care providers.<br>c. Ensure real time notification to a Health Home care manager as applicable | | |
| | Milestone #3 For patients presenting with minor illnesses who do not have a primary care provider:<br>a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need.<br>b. Patient navigator will assist the patient with identifying and accessing needed community support resources.<br>c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider). | Pass & Ongoing | |
| | Milestone #4 Established protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.) | Pass & Ongoing | |
| | Milestone #5 Use EHRs and other technical platforms to track all patients engaged in the project. | Pass & Ongoing | |
| 2.b.iv | Module 2.b.iv.2 - Patient Engagement Speed | Fail | |
| | Module 2.b.iv.3 - Prescribed Milestones | | |
| | Milestone #1 Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency. | Pass & Ongoing | |
| | Milestone #2 Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed. | Pass & Ongoing | |
| | Milestone #3 Ensure required social services participate in the project. | Pass & Ongoing | |
| | Milestone #4 Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services. | Pass & Ongoing | |
| | Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider. | Pass & Ongoing | |
| | Milestone #6 Ensure that a 30-day transition of care period is established. | Pass & Ongoing | |
| | Milestone #7 Use EHRs and other technical platforms to track all patients engaged in the project. | Pass & Ongoing | |
| 2.b.viii | Module 2.b.viii.2 - Patient Engagement Speed | Fail | |
| | Module 2.b.viii.3 - Prescribed Milestones | | |
| | Milestone #1 Assemble Rapid Response Teams (hospital/home care) to facilitate patient discharge to home and assure needed home care services are in place, including, if appropriate, hospice. | Pass & Ongoing | |
| | Milestone #2 Ensure home care staff have knowledge and skills to identify and respond to patient risks for readmission, as well as to support evidence-based medicine and chronic care management. | Pass & Ongoing | |
| | Milestone #3 Develop care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer. | Pass & Ongoing | |
| | Milestone #4 Educate all staff on care pathways and INTERACT-like principles. | Pass & Ongoing | |

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|---|---|---|---|
| | Milestone #5 Develop Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care. | Pass & Ongoing | |
| | Milestone #6 Create coaching program to facilitate and support implementation. | Pass & Ongoing | |
| | Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care. | Pass & Ongoing | |
| | Milestone #8 Integrate primary care, behavioral health, pharmacy, and other services into the model in order to enhance coordination of care and medication management. | Pass & Ongoing | |
| | Milestone #9 Utilize telehealth/telemedicine to enhance hospital-home care collaborations. | Pass & Ongoing | |
| | Milestone #10 Utilize interoperable EHR to enhance communication and avoid medication errors and/or duplicative services. | Pass & Ongoing | |
| | Milestone #11 Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions. | Pass & Ongoing | |
| | Milestone #12 Use EHRs and other technical platforms to track all patients engaged in the project. | Pass & Ongoing | |
| 2.d.i | Module 2.d.i.2 - Patient Engagement Speed | Pass & Ongoing | |
| | Module 2.d.i.3 - Prescribed Milestones | | |
| | Milestone #1 Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate. | Pass & Ongoing | |
| | Milestone #2 Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement. | Pass & Ongoing | |
| | Milestone #3 Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas. | Pass & Ongoing | |
| | Milestone #4 Survey the targeted population about healthcare needs in the PPS' region. | Pass & Ongoing | |
| | Milestone #5 Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency. | Pass & Ongoing | |
| | Milestone #6 Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10).<br>• This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member.<br>• Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104. | Pass & Ongoing | |
| | Milestone #7 Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period. | Pass & Ongoing | |

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| | Milestone #8 Include beneficiaries in development team to promote preventive care. | Pass & Ongoing | |
| | Milestone #9 Measure PAM(R) components, including:<br>• Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service.<br>• If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM(R) survey and designate a PAM(R) score.<br>• Individual member's score must be averaged to calculate a baseline measure for that year's cohort.<br>• The cohort must be followed for the entirety of the DSRIP program.<br>• On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation. • If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP.<br>• The PPS will NOT be responsible for assessing the patient via PAM(R) survey.<br>• PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes.<br>• Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis. | Pass & Ongoing | |
| | Milestone #10 Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons. | Pass & Ongoing | |
| | Milestone #11 Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education. | Pass & Ongoing | |
| | Milestone #12 Develop a process for Medicaid recipients and project participants to report complaints and receive customer service. | Pass & Ongoing | |
| | Milestone #13 Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R). | Pass & Ongoing | |
| | Milestone #14 Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources. | Pass & Ongoing | |
| | Milestone #15 Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations. | Pass & Ongoing | |
| | Milestone #16 Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member. | Pass & Ongoing | |
| | Milestone #17 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project. | Pass & Ongoing | |
| 3.a.i | Module 3.a.i.2 - Patient Engagement Speed | Fail | |
| | Module 3.a.i.3 - Prescribed Milestones | | |
| | Milestone #1 Co-locate behavioral health services at primary care practice sites. All participating primary care practices | Pass & Ongoing | |

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| | must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3. | | |
| | Milestone #2 Develop collaborative evidence-based standards of care including medication management and care engagement process. | Pass & Ongoing | |
| | Milestone #3 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs. | Pass & Ongoing | |
| | Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project. | Pass & Ongoing | |
| | Milestone #5 Co-locate primary care services at behavioral health sites. | Pass & Ongoing | |
| | Milestone #6 Develop collaborative evidence-based standards of care including medication management and care engagement process. | Pass & Ongoing | |
| | Milestone #7 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs. | Pass & Ongoing | |
| | Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project. | Pass & Ongoing | |
| | Milestone #9 Implement IMPACT Model at Primary Care Sites. | Pass & Ongoing | |
| | Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement. | Pass & Ongoing | |
| | Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model. | Pass & Ongoing | |
| | Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model. | Pass & Ongoing | |
| | Milestone #13 Measure outcomes as required in the IMPACT Model. | Pass & Ongoing | |
| | Milestone #14 Provide "stepped care" as required by the IMPACT Model. | Pass & Ongoing | |
| | Milestone #15 Use EHRs or other technical platforms to track all patients engaged in this project. | Pass & Ongoing | |
| 3.a.iv | Module 3.a.iv.2 - Patient Engagement Speed | Fail | |
| | Module 3.a.iv.3 - Prescribed Milestones | | |
| | Milestone #1 Develop community-based addiction treatment programs that include outpatient SUD sites with PCP integrated teams, and stabilization services including social services. | Pass & Ongoing | |
| | Milestone #2 Establish referral relationships between community treatment programs and inpatient detoxification services with development of referral protocols. | Pass & Ongoing | |
| | Milestone #3 Include a project medical director, board certified in addiction medicine, with training and privileges for use of buprenorphine and buprenorphine/naltrexone as well as familiarity with other withdrawal management agents. | Pass & Ongoing | |
| | Milestone #4 Identify and link to providers approved for outpatient medication management of opioid addiction who agree to provide continued maintenance therapy and collaborate with the treatment program and care manager. These may include practices with collocated behavioral health services, opioid treatment programs or outpatient SUD clinics. | Pass & Ongoing | |
| | Milestone #5 Develop community-based withdrawal management (ambulatory detoxification) protocols based upon | Pass & Ongoing | |

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| | evidence based best practices and staff training. | | |
| | Milestone #6 Develop care management services within the SUD treatment program. | Pass & Ongoing | |
| | Milestone #7 Form agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project. | Pass & Ongoing | |
| | Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project. | Pass & Ongoing | |
| 3.d.ii | Module 3.d.ii.2 - Patient Engagement Speed | Fail | |
| | Module 3.d.ii.3 - Prescribed Milestones | | |
| | Milestone #1 Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up. | Pass & Ongoing | |
| | Milestone #2 Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke. | Pass & Ongoing | |
| | Milestone #3 Develop and implement evidence-based asthma management guidelines. | Pass & Ongoing | |
| | Milestone #4 Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans. | Pass & Ongoing | |
| | Milestone #5 Ensure coordinated care for asthma patients includes social services and support. | Pass & Ongoing | |
| | Milestone #6 Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events. | Pass & Ongoing | |
| | Milestone #7 Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers. | Pass & Ongoing | |
| | Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project. | Pass & Ongoing | |
| 3.g.i | Module 3.g.i.2 - Patient Engagement Speed | Fail | |
| | Module 3.g.i.3 - Prescribed Milestones | | |
| | Milestone #1 Integrate Palliative Care into appropriate participating PCPs that have, or will have, achieved NCQA PCMH and/or APCM certification. | Pass & Ongoing | |
| | Milestone #2 Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice. | Pass & Ongoing | |
| | Milestone #3 Develop and adopt clinical guidelines agreed to by all partners including services and eligibility. | Pass & Ongoing | |
| | Milestone #4 Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS. | Pass & Ongoing | |
| | Milestone #5 Engage with Medicaid Managed Care to address coverage of services. | Pass & Ongoing | |

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|---|---|---|---|
| | Milestone #6 Use EHRs or other IT platforms to track all patients engaged in this project. | Pass & Ongoing | |
| 4.a.iii | Module 4.a.iii.2 - PPS Defined Milestones | Pass & Ongoing | |
| 4.b.i | Module 4.b.i.2 - PPS Defined Milestones | Pass & Ongoing | |