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

DSRIP Implementation Plan Project

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

TABLE OF CONTENTS

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

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

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

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

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, Q2 **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	**9,384,754**	**10,001,063**	**16,172,975**	**14,321,107**	**9,384,754**	**59,264,653**
Revenue Loss	**9,384,754**	**10,001,063**	**16,172,975**	**14,321,107**	**9,384,754**	**59,264,653**
Internal PPS Provider Bonus Payments	**11,261,705**	**12,001,276**	**19,407,569**	**17,185,329**	**11,261,705**	**71,117,584**
Cost of non-covered services	**3,753,902**	**4,000,426**	**6,469,190**	**5,728,443**	**3,753,902**	**23,705,863**
Other	**3,753,902**	**4,000,426**	**6,469,190**	**5,728,443**	**3,753,902**	**23,705,863**
Contingency for unforeseen developments over the life of the DSRIP project	3,753,902	4,000,426	6,469,190	5,728,443	3,753,902	23,705,863
Total Expenditures	**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 :

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	35,955,152	235,474,750

Budget Items	Quarterly Amount - Update		Remaining Balance in Current DY	Percent Remaining in Current DY	Cumulative Remaining Balance	Percent Remaining of Cumulative Balance
	DY1, Q1 ($)	DY1, Q2 ($)				
Cost of Project Implementation & Administration	59,216	1,524,649	7,800,889	83.12%	57,680,788	97.33%
Revenue Loss			9,384,754	100.00%	59,264,653	100.00%
Internal PPS Provider Bonus Payments			11,261,705	100.00%	71,117,584	100.00%
Cost of non-covered services			3,753,902	100.00%	23,705,863	100.00%
Other	0	0	3,753,902	100.00%	23,705,863	100.00%
Contingency for unforeseen developments over the life of the DSRIP project						
Total Expenditures	**59,216**	**1,524,649**				

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No Records Found

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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)

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	37,539,016.52	40,004,253.66	64,691,898.79	57,284,429.46	37,539,016.52	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	9,565,840	10,194,040	16,485,043	14,597,442	9,565,840	60,408,205
Total Funds Distributed	**37,539,017.00**	**40,004,254.00**	**64,691,899.00**	**57,284,429.00**	**37,539,017.00**	**237,058,616**
Undistributed Revenue	**0.00**	**0.00**	**0.00**	**0.46**	**0.00**	**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	35,955,152	235,474,750

Funds Flow Items	Quarterly Amount - Update		Percent Spent By Project											DY Adjusted Difference	Cumulative Difference
			Projects Selected By PPS												
	DY1 Q1	DY1 Q2	2.a.i	2.b.iii	2.b.iv	2.b.vii i	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)	0	0	0	0	0	0	0	0	0	0	0	0	0	6,113,343	38,605,718
Practitioner - Non-Primary Care Provider (PCP)			0	0	0	0	0	0	0	0	0	0	0	2,971,789	18,766,825
Hospital			0	0	0	0	0	0	0	0	0	0	0	13,264,484	83,765,120
Clinic			0	0	0	0	0	0	0	0	0	0	0	1,243,621	7,853,457
Case Management / Health Home			0	0	0	0	0	0	0	0	0	0	0	2,503,538	15,809,825
Mental Health			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	132,661	837,754
Nursing Home			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	105,891	668,700
Hospice			0	0	0	0	0	0	0	0	0	0	0	11,547	72,919
Community Based Organizations			0	0	0	0	0	0	0	0	0	0	0	579,882	3,661,951
All Other	59,216	1,524,649	0	0	0	0	0	0	0	0	0	0	0	7,981,975	58,824,340
Total Expenditures	**59,216**	**1,524,649**													

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
mccarrol	Documentation/Certification	3_MDL0118_1_2_20151021114507_DY1Q2 Report_Funds Flow_OMIG_FY14_15.xlsx	OMIG Required "DSRIP Peformance Payment Funds Flow" for the period 10/01/2014-09/30/2015	10/21/2015 11:47 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)

Narrative Text :

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 1.5 - 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	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2. Develop budget forms and collection tools to complete data requirements of flow of funds model	In Progress	2. Develop budget forms and collection tools to complete data requirements of flow of funds model	04/01/2015	09/30/2015	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	09/30/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
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	09/30/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
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	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
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	

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

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Complete funds flow budget and distribution plan and communicate with network	Task 2 , 3, and 4 originally dated 9/30 have been moved to 12/31/2015 to reflect the ongoing nature of this work. Budget and Workforce Templates have been developed. Collection tool is under development and data collection is expected to continue throughout fund flow model development. Likewise, Alliance will continue communication and engagement throughout the development of the fund flow model.

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 :

The IA has added guidance to modules 1,2,3, and 4.

New 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 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 1. Hold first AFBHC, LLC Governance meetings	Completed	a. Hold organizational meeting of Members (1) Ratify Operating Agreement (2) Ratify appointment of Board of Managers b. Hold organizational meeting of Board of Managers (1) Appoint Officers (Chairs, Vice Chair, Secretary) (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 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 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. 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	

New 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
		recommendation for and aligned CEO leadership and committee structure solution. "							
Task 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 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 Establish a clinical governance structure, including clinical quality committees for each DSRIP project	In Progress	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 1. Write charters for Clinical Integration and Quality Committee and for each subsidiary Project Steering Committee, consider the following in writing charters:	In Progress	a. Previously written Adequate Clinical Governance in Project Plan Application, Structure 3 b. Process for approving clinical protocols and best practices for all projects in collaboration with the Innovative Health Alliance of New York (IHANY) c. Define accountability for monitoring network's compliance with milestones and metrics	04/01/2015	09/30/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 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)	In Progress	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	09/30/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3. Finalize clinical organizational chart for Clinical Integration and Quality Committee and its subsidiary Project Steering Committees	In Progress	3. Finalize clinical organizational chart for Clinical Integration and Quality Committee and its subsidiary Project Steering Committees	04/01/2015	09/30/2015	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 4. Install members of the Project Steering Subcommittees, consider current work groups and newly-interested practitioners for membership	In Progress	4. Install members of the Project Steering Subcommittees, consider current work groups and newly-interested practitioners for membership	04/01/2015	09/30/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 5. Schedule and hold formal meetings of the Clinical Integration and Quality Committee with minutes	In Progress	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 6. Identify performance metrics to be reviewed by clinical committees, content and frequency of reports to be reviewed, and define committee members' oversight responsibilities.	In Progress	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	09/30/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 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 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 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 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 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 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 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 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 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 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 Establish governance structure reporting and monitoring processes	In Progress	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 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 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 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	In Progress	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 4. Write board recommendation for approval of governance structure, reporting, and monitoring policy	In Progress	4. Write board recommendation for approval of governance structure, reporting, and monitoring policy	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
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)	In Progress	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 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	In Progress	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 2. Develop community engagement plan referencing AFBHC Project Plan Application Governance Process 8 (How PPS Governing Body will Engage Stakeholders) including two-way communication	In Progress	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 3. Demonstrate implementation of community engagement plan through community forums, website, newsletter, and social media	In Progress	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	In Progress	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	

New 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
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 5. Schedule community engagement events for current year and subsequent year focusing on public and non-provider organizations	In Progress	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 Finalize partnership agreements or contracts with CBOs	In Progress	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 1. Write partnership agreements with performance addendums with CBOs	In Progress	a. Develop list of provider types that need agreements via feedback from project committees b. Identify specific expectations per provider type in reference to project performance c. Obtain provider services agreement from IHANY as a base, adapt to AFBHC, LLC d. Identify general provider expectations to be included in agreement and AFBHC obligations e. Develop provider and CBO incentive principles and payment methodology, which is part of the funds flow policy. 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 2. Conduct assessment of needed CBOs and develop contracting strategy	In Progress	a. Identify CBOs for contracting, prepare contracts, and schedule negotiations meetings 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 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 4. Maintain list of active signed provider agreements with filed electronic copies	In Progress	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 5. Develop and implement credentialing criteria and processes	On Hold	5. Develop and implement credentialing criteria and processes	04/01/2015	09/30/2015	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 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. b. Invite to the planning process the External Stakeholders listed in this section. c. Identify key issues and services needed from public sector agencies. d. Determine the role that each entity may play in the projects and if a contract is necessary to obtain services. 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 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 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 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 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 2. Identify workforce groups and evaluate general needs for communication	In Progress	a. Identify specific communication needs by workforce group and develop messages tailored to each group b. Identify methods and channels of communication best suited for each workforce group and develop distribution plan c. Discuss with employers and labor representatives impact of DSRIP on employees. 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 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 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 Inclusion of CBOs in PPS Implementation.	In Progress	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 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.	In Progress	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	In Progress	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 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.	In Progress	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

No Records Found

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_2_20151014094733_Meeting Templates Committees DY1Q2 report.pdf	Meeting templates - Finance, IT, Workforce, Audit and Compliance Committees. Please note official start date of Committees is subsequent to noted board action.	10/14/2015 09:47 AM
	mccarrol	Documentation/Certification	3_MDL0203_1_2_20151013172811_Oct 13 2015 Board of Managers Agenda and Item 5 Committee Membership Approved.pdf	Oct 13 2015 BOM Agenda & Item 5 Committee Membership (Fin, Wrkfrce, IT, Adt & Cmpliance). Clinical Integration and Quality Committee membership approved - will be uploaded w/M2	10/13/2015 05:28 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
	mccarrol	Documentation/Certification	3_MDL0203_1_2_20151013171107_Sept 11 2015 Board of Managers Minutes.pdf	Sept 11 2015 Board of Managers Minutes - please see item 8 (approved) Gov Committee Structure and Charters	10/13/2015 05:11 PM
	mccarrol	Documentation/Certification	3_MDL0203_1_2_20151013170149_Board Membership.docx	Board of Managers, denotes Members	10/13/2015 05:01 PM
	mccarrol	Documentation/Certification	3_MDL0203_1_2_20151008112411_7 b 5 Finance Committee Charter.doc	Finance Committee Charter	10/08/2015 11:24 AM
	mccarrol	Documentation/Certification	3_MDL0203_1_2_20151008111814_7 b 3 Workforce Committee Charter.doc	Workforce Committee Charter	10/08/2015 11:18 AM
	mccarrol	Documentation/Certification	3_MDL0203_1_2_20151008111738_7 b 4 Audit and Compliance Committee Charter.doc	Audit and Compliance Committee Charter	10/08/2015 11:17 AM
	mccarrol	Documentation/Certification	3_MDL0203_1_2_20151008111405_7 b 2 Information Technology Committee Charter.doc	Information Technology Committee Charter	10/08/2015 11:14 AM
	mccarrol	Documentation/Certification	3_MDL0203_1_2_20151008103328_AFBHC Fourth Amended Operating Agreement (FINAL Approved 9-11-2015).pdf	Charter for Gov Body = Operating Agreement Charters for Finance, IT, CIQC, Workforce, and Audit and Compliance Committees will be uploaded	10/08/2015 10:33 AM
	mccarrol	Documentation/Certification	3_MDL0203_1_2_20151008102338_AFBHC Governance Structure Diagram Approved.pptx	Organizational chart for the Governing Body and Committees. This does not include project specific sub-committees as these will be captured in a subsequent milestone.	10/08/2015 10:23 AM
Finalize bylaws and policies or Committee Guidelines where applicable	mccarrol	Documentation/Certification	3_MDL0203_1_2_20151211171011_Board_and_Committee_Membership_with_Roles_&_Responsibilities.docx	This document provides Alliance Committee membership along with roles and responsibility information that was required as remediation of Governance Milestone #1 DY1Q2 report.	12/11/2015 05:10 PM
	mccarrol	Documentation/Certification	3_MDL0203_1_2_20151211165949_Allinace_Board_Chair_DY1Q2_Governance_M1_Remediation_exhibits_D-F.pdf	These are exhibits D-F that go with signed letter from Board Chair. These 2 attachments establish Board approval of Governance Milestone # 1: DY1Q2 report remediation	12/11/2015 04:59 PM
	mccarrol	Documentation/Certification	3_MDL0203_1_2_20151211165655_Allinace_Board_Chair_DY1Q2_Governance_M1_Remediation_signed_letter_exhibits_A-C.pdf	Letter signed by Chair of Alliance board along with exhibits A-c submitted as remediation for DY1Q2 Governance Milestone 1 establishing Board approval	12/11/2015 04:56 PM
	mccarrol	Documentation/Certification	3_MDL0203_1_2_20151008153050_7 b 3 Workforce Committee Charter.doc	Workforce Committee Charter	10/08/2015 03:30 PM
	mccarrol	Documentation/Certification	3_MDL0203_1_2_20151008153024_7 b 4 Audit and Compliance Committee Charter.doc	Audit and Compliance Committee Charter	10/08/2015 03:30 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
	mccarrol	Documentation/Certification	3_MDL0203_1_2_20151008152951_7 b 2 Information Technology Committee Charter.doc	IT Committee Charter	10/08/2015 03:29 PM
	mccarrol	Documentation/Certification	3_MDL0203_1_2_20151008152926_7 b 5 Finance Committee Charter.doc	Finance Committee Charter	10/08/2015 03:29 PM
	mccarrol	Documentation/Certification	3_MDL0203_1_2_20151008145220_AFBHC Fourth Amended Operating Agreement (FINAL Approved 9-11-2015).pdf	Operating Agreement LLC does not have by-laws	10/08/2015 02:52 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize governance structure and sub-committee structure	Governance Committee Structure and Charters as approved at 9/11/2015 Board of Managers meeting are attached for Finance, IT, Workforce, and Audit and Compliance Committees. Clinical Integration and Quality Committee documentation will be uploaded as part of Milestone 2. 12/15/2015 - please see documentation attached under Governance Milestone 3 as remediation for Governance Milestone 1. Insufficient storage space to upload required documentation under Milestone 1 due to MAPP system limitations.
Establish a clinical governance structure, including clinical quality committees for each DSRIP project	End date for tasks 1-2-3-4 and 6 moved from 9/30 to 12/31/2015. Charter, groupings, membership, dashboards being further refined to insure adequate project specific quality focus. Will be reviewed at 11/2/2015 Clinical Integration and Quality Committee meeting.
Finalize bylaws and policies or Committee Guidelines where applicable	Operating Agreement uploaded. LLC does not have by-laws. Charters also uploaded.
Establish governance structure reporting and monitoring processes	
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	T5 "On-Hold" since Alliance providers will not be credentialed as part of DSRIP.
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.	

New 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 (with Exception) & Complete	The Milestone was Passed (with Exception) and Complete. The PPS demonstrated that it has created a governance structure therefore meeting the intent of the Milestone requirement, however the PPS did not comply with the IA request for additional documentation related to meeting minutes, agendas, or attendance sheets as part of remediation. The PPS will be expected to submit the requested documentation in future quarters.
Milestone #2	Pass & Ongoing	
Milestone #3	Pass & Complete	
Milestone #4	Pass & Ongoing	
Milestone #5	Pass & Ongoing	
Milestone #6	Pass & Ongoing	
Milestone #7	Pass & Ongoing	
Milestone #8	Pass & Ongoing	
Milestone #9	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 2.2 - 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

New 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
		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
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
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

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 Finalize PPS finance structure, including reporting structure	In Progress	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 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 2. Develop financial budgeting and reporting process working with providers, partners and project leads.	In Progress	2. Develop financial budgeting and reporting process working with providers, partners and project leads.	04/01/2015	09/30/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3. Finance Committee briefs AFBHC Governance Board on budgeting and reporting process; process adopted by Board.	In Progress	3. Finance Committee briefs AFBHC Governance Board on budgeting and reporting process; process adopted by Board.	04/01/2015	09/30/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 4. Communicate reporting process to provider network	In Progress	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 5. Begin reporting structure for AFBHC	In Progress	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 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: - identify those providers in their network that are financially fragile, including those that have qualified as IAAF providers; -- 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

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
		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; -- include any additional financial indicators that they deem necessary for monitoring the financial sustainability of their network providers							
Task 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	12/31/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 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	12/31/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 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	In Progress	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	09/30/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 4. Additional data as needed collected from financially distressed providers including the completion of the DPP where determined needed.	In Progress	4. Additional data as needed collected from financially distressed providers including the completion of the DPP where determined needed.	06/01/2015	09/30/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 5. Finalize Distressed Provider Plan (DPP) report and process for monitoring	In Progress	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 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
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
assessment to AFBHC Governing board									
Milestone #3 Finalize Compliance Plan consistent with New York State Social Services Law 363-d	In Progress	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	In Progress	4. Monitor completion of performance program on a quarterly basis	04/01/2015	09/30/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 5. Complete annual Compliance Certification required by OMIG	In Progress	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	In Progress	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	In Progress	1. AFBHC staff, in collaboration with Finance Committee,	04/01/2015	09/30/2015	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 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.	In Progress	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	09/30/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 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	09/30/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 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 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	09/30/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 6. Providers share input using survey tool on VBP methods, contracting and preferred compensation modalities which is compiled by AFBHC staff.	In Progress	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	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)

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 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 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 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 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 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 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 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

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize PPS finance structure, including reporting structure	Task 2 and 3, originally dated 9/30 have been moved to 12/31/2015. Administrative Budget has been developed and approved. Project budget templates have been developed and distributed. Reporting process is undergoing continued refinement. Finance Committee reports out to Board monthly and will brief Board on financial reporting process when finalized.
Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	Original due date for T3 and T4 was 9/30. However, this has been moved to 12/31/2015 to reflect the ongoing nature of this work. Data has been requested from members and partners with significant attributed lives. If necessary, Alliance will ask financially distressed providers to complete the Distressed Provider Plan.
Finalize Compliance Plan consistent with New York State Social Services Law 363-d	Original due date for T4 was 9/30. However, this has been moved to 12/31/2015 to reflect the ongoing nature of this work (quarterly update).
Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	The original date 9/30 for T1, T2, and T3 changed to 12/31/2015. Questionnaire, requesting data on current value based arrangements, has been developed, sent out, and responded to. Not at 100% response rate, so data review is continuing. The original date 9/30 for T5 has been changed to 12/31//2015. Materials have been presented to the Board, and link to VBP road map and other materials have been posted to Alliance website. Date change reflects on-going nature of roll-out.
Finalize a plan towards achieving 90% value-based 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)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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 & 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 3.2 - 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 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

New 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
		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

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 Finalize cultural competency / health literacy strategy.	In Progress	This milestone must be completed by 12/31/2015. Cultural competency / health literacy strategy signed off by PPS Board. The strategy should: -- Identify priority groups experiencing health disparities (based on your CNA and other analyses); -- Identify key factors to improve access to quality primary, behavioral health, and preventive health care -- Define plans for two-way communication with the population and community groups through specific community forums -- Identify assessments and tools to assist patients with self-management of conditions (considering cultural, linguistic and literacy factors); and -- 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 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 2. Refine PPS strategy defined in the Cultural Competency/Health Literacy DSRIP application. Plan will include the following:	In Progress	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	In Progress	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	

New 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. 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 "	In Progress	"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 "	In Progress	"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	In Progress	"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.	In Progress	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	In Progress	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	In Progress	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.	In Progress	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: -- Training plans for clinicians, focused on available evidence-based research addressing health disparities for particular groups identified in your cultural competency strategy -- 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	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
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	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
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 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 "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) "	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) "	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 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 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	

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

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize cultural competency / health literacy strategy.	
Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-	

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
appropriate material).	

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 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

New 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
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 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

New 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
		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 "
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 SUNY"	Contribute experience from the HPOG demonstration project	Post-secondary program collaboration

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

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 :

New 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
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

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

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 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 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 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 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 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 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 Develop an IT Change Management Strategy.	In Progress	IT change management strategy, signed off by PPS Board. The strategy should include: -- Your approach to governance of the change process; -- A communication plan to manage communication and involvement of all stakeholders, including users; -- An education and training plan; -- An impact / risk assessment for the entire IT change process; and -- 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 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 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	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 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	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 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 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 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 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 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 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: -- A governance framework with overarching rules of the road for interoperability and clinical data sharing; -- A training plan to support the successful implementation of new platforms and processes; and -- Technical standards and implementation guidance for sharing and using a common clinical data set -- 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
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 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	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
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	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
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	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
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	In Progress	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	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
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	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
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 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 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 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 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 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 Develop a data security and confidentiality plan.	In Progress	Data security and confidentiality plan, signed off by PPS Board, including: -- Analysis of information security risks and design of controls to mitigate risks -- 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 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 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 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
Perform current state assessment of IT capabilities across network, identifying any	mccarrol	Documentation/Certification	3_MDL0503_1_2_20151027103426_Meeting Template IT.xlsx	Committee Meeting Template IT	10/27/2015 10:34 AM

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
critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s).	mccarrol	Documentation/Certification	3_MDL0503_1_2_20151013124559_20150510_AFBHC_IT_Assessment_Preliminary_Findings_V03.pdf	IT Assessment Preliminary Findings	10/13/2015 12:45 PM
	mccarrol	Documentation/Certification	3_MDL0503_1_2_20151013124458_20150330_AFBHC_IT_Requirements_and_Gap_Analysis.pdf	IT Requirements and Gap Assessment	10/13/2015 12:44 PM
Develop a data security and confidentiality plan.	mccarrol	Documentation/Certification	3_MDL0503_1_2_20151211172150_Response_to_DY1Q2_Remediation_Checklist_IT_Module_5.1,_Milestone_5.docx	Additional narrative to the Data Security Narrative in Lieu of Workbooks submitted with the DY1Q2 report. This is being provided as remediation required for Module 5.1,Milestone #5	12/11/2015 05:21 PM
	mccarrol	Documentation/Certification	3_MDL0503_1_2_20151028110551_Data Security Narrative in Lieu of Workbooks.pdf	Required Data Security Narrative in Lieu of Workbooks	10/28/2015 11:05 AM

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).	Completed initial IT assessment focused on inter connectivity through the RHIO and generally understood requirements for DSRIP (e.g., meaningful use attestation, EMR use, and PCMH NCQA accreditation) alongside relevant QE (Hixny, the RHIO). Alliance will conduct additional assessment as needed reflecting any changes to the program that DOH may dictate. Alliance will also conduct additional assessment as necessary to reflect any new requirements including hardware and software infrastructure, staffing, and security and confidentiality requirements. The IT Committee Committee was approved by the Board subsequent to the meetings referenced on the attached template. The official start date for IT Committee meetings is 9/11/2015.
Develop an IT Change Management Strategy.	
Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network	
Develop a specific plan for engaging attributed members in Qualifying Entities	
Develop a data security and confidentiality plan.	

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass & Ongoing	
Milestone #2	Pass & Ongoing	
Milestone #3	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 #4	Pass & Ongoing	
Milestone #5	Pass & Ongoing	This milestone is Pass and Ongoing pending final review of security workbooks by DOH

New 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 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: -- The identification of individuals responsible for clinical and financial outcomes of specific patient pathways; -- Your plans for the creation and use of clinical quality & performance dashboards -- 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 1. Establish reporting structure for PPS wide-performance reporting and communication.	In Progress	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 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.	In Progress	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 3. Identify required Domains 2, 3, and 4 metrics defining Measure Steward, Data Sources, and timelines for reporting and performance.	In Progress	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 4. Define clinical and financial performance key performance indicators with PPS-wide executive leadership beyond DSRIP.	In Progress	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 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	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
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.	In Progress	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.	In Progress	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	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
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	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
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 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 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	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 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	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task "3. Identify specific themes to be included in the training program: a. Success factors in a training program associated with the use of performance data b. The role played by function-specific and project-specific leadership c. The role of performance reporting in creating accountability "	In Progress	"3. Identify specific themes to be included in the training program: a. Success factors in a training program associated with the use of performance data b. The role played by function-specific and project-specific leadership c. The role of performance reporting in creating accountability "	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 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 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.	
Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting.	

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

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 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 Develop Practitioners communication and engagement plan.	In Progress	Practitioner communication and engagement plan. This should include: -- Your plans for creating PPS-wide professional groups / communities and their role in the PPS structure -- The development of standard performance reports to professional groups --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 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 b. Recruit practitioner members to Task Force c. Write expectations and goals of Task Force d. Ask co-chairs to participate and meet to review goals e. Identify facilitator "	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2. Develop practitioner communication and engagement plan	Completed	a. Identify role each provider type will play in projects b. Identify common communication needs for all providers c. Identify specific communication needs by provider type d. Develop PPS-wide professional groups e. Identify standard professional reports by provider types f. Identify timetable for needed communications, tailoring the communication by phase of project implementation g. Identify best methods of communication by provider types 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 3. Begin implementation of communication and engagement plan	In Progress	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 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 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 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 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. c. Identify frequency of training throughout the life of the DSRIP projects and beyond, target training content to the life cycle of each project d. Consider qualifying curriculum for continuing education credits e. Submit draft training/education plan to Workforce Committeee. Present training/education plan to other relevant committees/groups f. Develop survey of practitioners to assess their satisfaction with the type and amount of engagement from the PPS "	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

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop Practitioners communication and engagement plan.	
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.	

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 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 Develop population health management roadmap.	In Progress	Population health roadmap, signed off by PPS Board, including: -- The IT infrastructure required to support a population health management approach -- Your overarching plans for achieving PCMH 2014 Level 3 certification in relevant provider organizations --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 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	09/30/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 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	

New 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
		b. Formally adopt the PHM model at the Clinical Integration and Quality Committee and Subcommittees c. Formally adopt the PHM model at the Board of Managers. "							
Task 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 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 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 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 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 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 "9. Establish a schedule for monitoring progress to achieving PCMH 2013 Level 3 certification "	In Progress	"a. Based on analysis of pros/cons of corporate vs individual practice NCQA PCMH recognition, select approach(es) for provider groups. b. Collect NCQA recognition documentation from practices	04/01/2015	09/30/2015	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
		who are currently 2014 or 2011 Level 3 recognized (60% of PPS PCPs). d. Establish goals and timelines to achieve 2014 Level 3 NCQA recognition by the end of DY3. e. Asses the practices' needs for technical assistance and provide technical assistance. f. Establish a method to track and report progress on a regular basis. "							
Task 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 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 b. Establish feedback systems to monitor effectiveness of population health tools and processes for rapid resolution of challenges "	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 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 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 "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. 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. "		roadmap b. Report findings of bed utilization reports to leadership of PPS after assessments completed "							
Task 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.	The 9/30 date for T1 and T9 have been moved to 12/31/2015. Alliance has established a Clinical Integration and Quality Committee with project specific sub-committees and is presently recruiting for a Director of Provider Transformation to lead the PCMH effort. In addition, a VP for Health Transformation is being recruited to oversee the work of the clinical projects, help to advance the Alliance Population Health strategy and support the efforts of the Clinical Integration and Quality Committee.
Finalize PPS-wide bed reduction 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)

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

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 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 9-24-15 Scott Momrow	Support connectivity	Providers are able to share patient information across the PPS
Public Health representatives 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 9-24-15: Cathy Homkey, CEO	Neighboring DSRIP PPS	Coordination of population health management
Albany Medical Center PPS 9-24-15: George Clifford, Evan Brooksby, & Dr. Fredrick Venditti	Neighboring DSRIP PPS	Coordination of population health management
Leatherstocking Collaborative Health PPS 9-24-15: Sue van der Sommen, Executive Director	Neighboring DSRIP PPS	Coordination of population health management
All New York State PPSs 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

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

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 Perform a clinical integration 'needs assessment'.	In Progress	Clinical integration 'needs assessment' document, signed off by the Clinical Quality Committee, including: -- 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) -- Identifying key data points for shared access and the key interfaces that will have an impact on clinical integration -- 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 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	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 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	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
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 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	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 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	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 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 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	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 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 Develop a Clinical Integration strategy.	In Progress	Clinical Integration Strategy, signed off by Clinical Quality Committee, including: -- Clinical and other info for sharing -- Data sharing systems and interoperability -- 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 -- Training for providers across settings (inc. ED, inpatient, outpatient) regarding clinical integration, tools and communication for coordination -- 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 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	In Progress	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 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	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 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	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
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 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'.	
Develop a Clinical Integration strategy.	

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.

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

DSRIP Implementation Plan Project

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

New 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
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

New 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 9.6 - 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.

New 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 10.2 - 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
Delivery System Reform Incentive Payment Project

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.

New 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
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

New 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
		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

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

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.

New 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 10.7 - 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 :

New 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 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

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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 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	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	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	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	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	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	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	03/31/2016	DY1 Q4	
Task 7. The WC shall consider PAC suggestions and	In Progress	7. The WC shall consider PAC suggestions and recommendations into further defining the target workforce			09/30/2015	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
recommendations into further defining the target workforce state.		state.							
Task 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	03/31/2016	DY1 Q4	
Milestone #2 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	03/31/2016	DY1 Q4	NO
Task 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	DY1 Q3	
Task 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	03/31/2016	DY1 Q4	
Task 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	03/31/2016	DY1 Q4	
Task 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	03/31/2016	DY1 Q4	
Task 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	03/31/2016	DY1 Q4	
Task 6. The WC shall consider PAC suggestions and recommendations into further developing the	In Progress	6. The WC shall consider PAC suggestions and recommendations into further developing the workforce transition roadmap.			09/30/2015	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
workforce transition roadmap.									
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	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	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	DY1 Q3	
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	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	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	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	03/31/2016	DY1 Q4	
Task 6. The WC will provide a final updated and	In Progress	6. The WC will provide a final updated and required Workforce Strategy Budget, Workforce Impact Analysis, and			09/30/2015	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
required Workforce Strategy Budget, Workforce Impact Analysis, and New Hire Employment Analysis for the DY1, Q4 quarterly report.		New Hire Employment Analysis for the DY1, Q4 quarterly report.							
Task 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	03/31/2016	DY1 Q4	
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.	In Progress	Compensation and benefit analysis report, signed off by PPS workforce governance body.			09/30/2015	06/30/2016	06/30/2016	DY2 Q1	YES
Task 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	03/31/2016	DY1 Q4	
Task 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	03/31/2016	DY1 Q4	
Task 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	03/31/2016	DY1 Q4	
Task 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	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
Milestone #5 Develop training strategy.	In Progress	Finalized training strategy, signed off by PPS workforce governance body.			09/30/2015	03/31/2016	03/31/2016	DY1 Q4	NO
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.	In Progress	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	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	DY1 Q3	
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	DY1 Q3	
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	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	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	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	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.	
Perform detailed gap analysis between current state assessment of workforce and projected future state.	
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.	

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

New 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 11.4 - 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

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

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.

New 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 11.6 - 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

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

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

New 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 11.7 - 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

New 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
		Management, and Leadership Development.

New 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 11.8 - 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.

New 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 11.11 - 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.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

DSRIP Implementation Plan Project

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

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 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 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 1. Complete full provider list of all AFBHC participants, including medical, behavioral, post-acute and long term care providers	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 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. 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		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 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	12/31/2015	12/31/2015	DY1 Q3
Task	Project		In Progress	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)

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
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 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 agreements/contracts	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task	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
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.	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
Task 4. As part of the Part I IT Systems and Processes plan, assess the population health management IT tools and systems used	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
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 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 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 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 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 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 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 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 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 3. Incorporating best practices, document with a flow diagram the care management workflow / patient flow among the PPS partners and CBOs.	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

New 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
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 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 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 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 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 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.	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 connectivity to RHIO's HIE and SHIN-NY	Provider	Safety Net Practitioner - Primary Care Provider	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
requirements.		(PCP)							
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
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	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
implementation.									
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	12/31/2015	12/31/2015	DY1 Q3
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	12/31/2015	12/31/2015	DY1 Q3
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	Project		In Progress	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)

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
processes.									
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	12/31/2015	12/31/2015	DY1 Q3
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	12/31/2015	12/31/2015	DY1 Q3
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	12/31/2015	12/31/2015	DY1 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 and processes	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
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	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
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).	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		In Progress	04/01/2015	09/30/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Establish PCMH project team	Project		In Progress	04/01/2015	09/30/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
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	12/31/2015	12/31/2015	DY1 Q3
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.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
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	12/31/2015	12/31/2015	DY1 Q3
Task 6. Based on analysis of pros/cons of corporate vs individual practice NCQA PCMH recognition, select approach(es) for	Project		In Progress	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)

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
provider groups									
Task 7. Determine level of support with financial implications for AFBHC	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
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	12/31/2015	12/31/2015	DY1 Q3
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	12/31/2015	12/31/2015	DY1 Q3
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	12/31/2015	12/31/2015	DY1 Q3
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 provide technical assistance.	Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 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 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	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
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).	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 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 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 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 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 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
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	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
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	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 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.	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 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).	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
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	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
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 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
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

New 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. 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 organization, PCMH, clinical program).	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
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	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
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 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.										
Task PPS includes continuum of providers in IDS, including medical, behavioral health, post-acute, long-term care, and community-based providers.										
Task 1. Complete full provider list of all AFBHC participants, including medical, behavioral, post-acute and long term care providers										
Task 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. 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.										

New 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 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 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 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 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 7. Project future capacity needs per DSRIP project based on the patient and provider engagement timelines identify gaps or 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										

New 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 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.										
Task 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										

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
attribution capabilities.										
Task 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 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 Clinically Interoperable System is in place for all participating providers.										
Task PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS.										
Task PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are followed.										
Task PPS trains staff on IDS protocols and processes.										
Task 1. Create the AFBHC centralized Clinical Integration and Quality Department to coordinate and align care management across the PPS.										
Task 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 3. Incorporating best practices, document with a flow diagram the care management workflow / patient flow among the PPS partners and CBOs.										
Task 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 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										

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 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 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 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 8. Implement selected care transitions model in Projects 2.b.iv. and 2.b.viii										
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.										
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										

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
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 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										

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
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										
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										

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
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.	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										

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
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.)										
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										

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
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 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										

New 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. 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.										
Task 3. Establish incentive compensation to patient outcomes consistent with DSRIP goals considering the budget and funds flow framework.										
Task 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 5. Establish communication schedule to present the VBP Educational Program										
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										
Task 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 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.										

New 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 Community health workers and community-based organizations utilized in IDS for outreach and navigation activities.										
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.										
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).										
Task 3. Determine strategy for apprising community assessment information, including determination of repeating assessment within the DSRIP calendar timeframe										
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										

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. 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 various projects across the PPS, with emphasis on 2di project alignment										
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.										
Task 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 All PPS providers must be included in the Integrated Delivery										

New 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
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 PPS includes continuum of providers in IDS, including medical, behavioral health, post-acute, long-term care, and community-based providers.										
Task 1. Complete full provider list of all AFBHC participants, including medical, behavioral, post-acute and long term care providers										
Task 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. 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 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 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 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 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										

New 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
Quality Committee										
Task 7. Project future capacity needs per DSRIP project based on the patient and provider engagement timelines identify gaps or 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.										

New 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 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.										
Task 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 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 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 Clinically Interoperable System is in place for all participating providers.										
Task PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS.										
Task PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are followed.										
Task PPS trains staff on IDS protocols 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)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task 1. Create the AFBHC centralized Clinical Integration and Quality Department to coordinate and align care management across the PPS.										
Task 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 3. Incorporating best practices, document with a flow diagram the care management workflow / patient flow among the PPS partners and CBOs.										
Task 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 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 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 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 8. Implement selected care transitions model in Projects 2.b.iv. and 2.b.viii										
Milestone #4 Ensure that all PPS safety net providers are actively sharing EHR systems with local health information										

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
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 EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	42	55	55	55	55	55	55	55	55	55
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	59	78	78	78	78	78	78	78	78	78
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	9	12	12	12	12	12	12	12	12	12
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										

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 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.	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										

New 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. 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 Models for all participating PCPs, expand access to 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
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 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										

New 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 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 2015).										
Milestone #9 Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.										

New 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 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.										
Task 3. Establish incentive compensation to patient outcomes consistent with DSRIP goals considering the budget and funds flow framework.										
Task 4. Develop VBP Educational Program explaining the content and implications of Level 1, 2, and 3 Value Based Payments as it										

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
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										
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										
Task 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 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 Community health workers and community-based organizations utilized in IDS for outreach and navigation activities.										
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.										
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).										
Task 3. Determine strategy for apprising community assessment information, including determination of repeating assessment within the DSRIP calendar timeframe										
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.										

New 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
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 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										

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
taught in multiple languages. (Stanford Chronic Disease Self-Management model or similar program).										
Task 15. Coordinate activities with patient activation measures in various projects across the PPS, with emphasis on 2di project alignment										
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.										
Task 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.	
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.	The 9/30 date for T1 has been moved to 12/31/2015. Alliance has established a Clinical Integration and Quality Committee with project specific sub-committees and is presently recruiting for a Director of Provider Transformation to lead the PCMH effort. In addition, a VP for Health Transformation is being recruited to oversee the work of the clinical projects, help to advance the Alliance Population Health strategy and support the efforts of the Clinical Integration and Quality Committee. Alliance is committed to leveraging existing care coordination and quality initiatives across the PPS and it will coordinate closely with existing Health Homes and other providers to foster collaboration and ensure a seamless transition for individuals to move across one setting to another in our health care eco system.
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	

New 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
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.	
Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	
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.	The 9/30 date for T1 and T2 has been moved to 12/31/2015. Alliance has established a Clinical Integration and Quality Committee with project specific sub-committees and is presently recruiting for a Director of Provider Transformation to lead the PCMH effort. In addition, a VP for Health Transformation is being recruited to oversee the work of the clinical projects, help to advance the Alliance Population Health strategy and support the efforts of the Clinical Integration and Quality Committee. Alliance is committed to leveraging existing care coordination and quality initiatives across the PPS and it will coordinate closely with existing Health Homes and other providers to foster collaboration and ensure a seamless transition for individuals to move across one setting to another in our health care eco system.
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	

New 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	
Milestone #9	Pass & Ongoing	
Milestone #10	Pass & Ongoing	
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

Patient Update		% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
DY1, Q1	DY1,Q2			
182	409	6.75%	5,647	1.20%

Warning: Please note that your patients engaged to date does not meet your committed amount (6,056)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
mccarrol	Documentation/Certification	3_null_1_2_20151028153303_DY1Q2_REGISTRY_2.b.iii.xlsx	DY1Q2 Patient Registry 2.b.iii	10/28/2015 03:33 PM

Narrative Text :

Module Review Status

Review Status	IA Formal Comments
Fail	The PPS failed to meet at least 80% of its Actively Engaged commitments for 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)

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. • 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 6. Conduct monthly meetings with project lead and teams from	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
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 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 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 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 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 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 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 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 Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling. a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3. b. Develop process and procedures to establish connectivity	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
between the emergency department and community primary care providers. c. Ensure real time notification to a Health Home care manager as applicable									
Task 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 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 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 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 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 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	12/31/2015	12/31/2015	DY1 Q3
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.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 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 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	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task	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
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	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	12/31/2015	12/31/2015	DY1 Q3
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	12/31/2015	12/31/2015	DY1 Q3
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	12/31/2015	12/31/2015	DY1 Q3
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: 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. b. Patient navigator will assist the patient with identifying and accessing needed community support resources. c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 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

New 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 1. Assess current state ED triage flow for target, at-risk populations as defined in Requirement #1, step #8	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Consider scope of roles and responsibilities of patient navigator, such as: • Evaluate (in person or follow up next day) of all ED Visits by Medicaid Members meeting level 4 or 5 • Assess with member to arrange for a post ED follow up PCP visit or re-connectively to their exiting PCP. • Assess transportation needs/barriers. Connect member with Medicaid Answering Services for covered health care appointments • 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. • 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 • 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	12/31/2015	12/31/2015	DY1 Q3
Task 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	12/31/2015	12/31/2015	DY1 Q3
Task 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
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	Project		In Progress	09/01/2015	03/31/2018	09/01/2015	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
navigator									
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	12/31/2015	12/31/2015	DY1 Q3
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	12/31/2015	12/31/2015	DY1 Q3
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 track education sessions	Project		In Progress	11/01/2015	03/31/2017	11/01/2015	03/31/2017	03/31/2017	DY2 Q4
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	Project		In Progress	04/01/2016	03/31/2018	04/01/2016	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
appropriate									
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
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	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
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	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

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 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										

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
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. • 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 3. Identify and invite key stakeholders to project teams, such as EMS, law enforcement, transportation, housing, community services and public organizations and practitioners.										
Task 4. Pilot program at St Mary's Hospital ED for initial roll out of project and stage implementation of other EDs										
Task 5. Form project implementation teams at each site, including ED administrative and front line staff and PPS providers										
Task 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 7. Identify process metrics, institute tracking mechanism to collect data, manually then progression to IT platform										
Task 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 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 10. Identify and communicate with project teams baseline metrics and potentially preventable ED visit salient data results										

New 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 11. Add PCMH staff to project teams to coordinate open access scheduling and other PCMH requirements of project										
Task 12. Track and evaluate programs at each site 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 #2 Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling. a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3. b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers. c. Ensure real time notification to a Health Home care manager as applicable										
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.	0	0	0	0	0	0	0	0	9	21
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 Encounter Notification Service (ENS) is installed in all PCP offices and EDs	0	0	0	0	0	0	0	0	9	21
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs	0	0	0	0	0	0	0	0	2	5
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.										

New 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. 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 navigators at rolled out sites. See Milestone #5										
Milestone #3 For patients presenting with minor illnesses who do not have a primary care provider: 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. b. Patient navigator will assist the patient with identifying and accessing needed community support resources. c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary										

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 provider).										
Task A defined process for triage of patients from patient navigators to non-emergency PCP and needed community support resources is in place.										
Task 1. Assess current state ED triage flow for target, at-risk populations as defined in Requirement #1, step #8										
Task 2. Consider scope of roles and responsibilities of patient navigator, such as: • Evaluate (in person or follow up next day) of all ED Visits by Medicaid Members meeting level 4 or 5 • Assess with member to arrange for a post ED follow up PCP visit or re-connectively to their exiting PCP. • Assess transportation needs/barriers. Connect member with Medicaid Answering Services for covered health care appointments • 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. • 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 • 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 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 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										

New 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
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										
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										

New 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
reconciliation, poly-pharmacy and adherence to prescribed treatment regimen.										
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.)										
Task 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 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 for ED Triage project										
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.										
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, 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										

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
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 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. • 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 3. Identify and invite key stakeholders to project teams, such as EMS, law enforcement, transportation, housing, community services and public organizations and practitioners.										
Task 4. Pilot program at St Mary's Hospital ED for initial roll out of										

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
project and stage implementation of other EDs										
Task 5. Form project implementation teams at each site, including ED administrative and front line staff and PPS providers										
Task 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 7. Identify process metrics, institute tracking mechanism to collect data, manually then progression to IT platform										
Task 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 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 10. Identify and communicate with project teams baseline metrics and potentially preventable ED visit salient data results										
Task 11. Add PCMH staff to project teams to coordinate open access scheduling and other PCMH requirements of project										
Task 12. Track and evaluate programs at each site 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 #2 Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling. a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3.										

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
b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers. c. Ensure real time notification to a Health Home care manager as applicable										
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.	37	55	55	55	55	55	55	55	55	55
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 Encounter Notification Service (ENS) is installed in all PCP offices and EDs	37	55	55	55	55	55	55	55	55	55
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs	8	12	12	12	12	12	12	12	12	12
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										

New 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 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 navigators at rolled out sites. See Milestone #5										
Milestone #3 For patients presenting with minor illnesses who do not have a primary care provider: 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. b. Patient navigator will assist the patient with identifying and accessing needed community support resources. 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 A defined process for triage of patients from patient navigators to non-emergency PCP and needed community support resources is in place.										
Task 1. Assess current state ED triage flow for target, at-risk populations as defined in Requirement #1, step #8										
Task 2. Consider scope of roles and responsibilities of patient navigator, such as: • Evaluate (in person or follow up next day) of all ED Visits by Medicaid Members meeting level 4 or 5 • Assess with member to arrange for a post ED follow up PCP visit or re-connectively to their exiting PCP.										

New 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
• Assess transportation needs/barriers. Connect member with Medicaid Answering Services for covered health care appointments • 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. • 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 • 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 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 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										

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 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										
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.										
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.)										
Task 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 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										

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
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 for ED Triage project										
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.										
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, 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										

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
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. a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3. b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers. c. Ensure real time notification to a Health Home care manager as applicable	
For patients presenting with minor illnesses who do not have a primary care provider: 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. b. Patient navigator will assist the patient with identifying and accessing needed community support resources. c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).	
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.)	

New 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 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

Patient Update		% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
DY1, Q1	DY1,Q2			
152	330	9.61%	3,105	1.22%

Warning: Please note that your patients engaged to date does not meet your committed amount (3,435)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
mccarrol	Documentation/Certification	3_null_1_2_20151028153435_DY1Q2_REGISTRY_2.b.iv.xlsx	DY1Q2 Patient Registry 2.b.iv	10/28/2015 03:34 PM

Narrative Text :

Module Review Status

Review Status	IA Formal Comments
Fail	The PPS failed to meet at least 80% of its Actively Engaged commitments for 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)

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, including level of engagement	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 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	12/31/2015	12/31/2015	DY1 Q3
Task 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 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 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 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 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 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 9-24-15: Remediation Response 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.	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
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, hospitals, and PPS will play.	Project		In Progress	09/01/2015	12/31/2017	09/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 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	Project		In Progress	09/01/2015	03/31/2018	09/01/2015	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. 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.	Project		In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #3 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 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 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. 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 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 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 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 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.	Project	N/A	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 - Primary Care Provider (PCP)	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 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	12/31/2015	12/31/2015	DY1 Q3
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	12/31/2015	12/31/2015	DY1 Q3
Task 3. Clinical Integrated Teams will collaborate with the care transitions coach to coordinate identified high-risk needs post-acute hospitalization	Project		In Progress	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	12/31/2015	12/31/2015	DY1 Q3
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	12/31/2015	12/31/2015	DY1 Q3
Task 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 7. Clinical Operations and Project Implementation teams will	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
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 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 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 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 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	12/31/2015	12/31/2015	DY1 Q3
Task 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 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	12/31/2015	12/31/2015	DY1 Q3
Task 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 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 Policies and procedures reflect the requirement that 30 day	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
transition of care period is implemented and utilized.									
Task 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 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 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 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 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
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

New 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. 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 alternative 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 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

New 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 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.										
Task 5. Develop a post-acute network for the PPS community, including level of engagement										
Task 6. Develop a standardized protocol for integrated clinical teams to manage population health strategies of Care Transitions services from inpatient to discharge										
Task 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 8. Establish a best practice model of service utilizing a Coleman-like model of care transitions with participating providers and CBO's										
Task 9. Complete an assessment of participating providers, LTC and CBO's of targeted high risk diagnosis (Core Measure,										

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
developmentally disabled, physical rehabilitation, & Behavioral Health/SUD), social barriers (Homeless, underinsured) and hot spotting										
Task 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 11. Present standardized protocols to appropriate Clinical Integration subcommittees and Clinical Integration and Quality Committee for formal adoption.										
Task 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 9-24-15: Remediation Response 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 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.										
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.										

New 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. 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.										
Task Required network social services, including medically tailored home food services, are provided in care transitions.										
Task 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. Submit strategies to project team and AFBHC leadership to review and for approval.										
Task 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 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										

New 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. 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 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 Policies and procedures are in place for early notification of planned discharges.	0	0	0	0	84	197	337	506	506	506
Task Policies and procedures are in place for early notification of planned discharges.	0	0	0	0	64	148	254	381	381	381
Task Policies and procedures are in place for early notification of planned discharges.	0	0	0	0	2	5	9	13	13	13
Task PPS has program in place that allows care managers access to visit patients in the hospital and provide care transition services and advisement.										
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										
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)										
Task 3. Clinical Integrated Teams will collaborate with the care transitions coach to coordinate identified high-risk needs post-acute hospitalization										
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.										
Task 5. Initiate steps identified in # 1, Step 7 utilizing teach back and/or return demonstration technique										

New 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. 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 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 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 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.										
Task 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.										
Task 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 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 3. The Clinical Operations & Project Implementation team will survey participating providers to extract additional ideas surrounding timely notification of post-acute discharge dispositions										
Task 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 Ensure that a 30-day transition of care period is established.										

New 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 Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.										
Task 1. Eligible patients enrolled in a high risk readmission process for 30-days transitions period will be assigned a care transitions coach										
Task 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 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 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.										
Task 5. Track , measure and evaluate care transition programs effectiveness through data, feedback and outcomes, report through Clinical Integration and Quality committee										
Milestone #7 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 for Care Transitions project										
Task 3. Working with the project committee, document current 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
future state work flow of Care Transitions project 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 implementation new EHR systems vs RHIO connectivity based on the DSRIP project needs and associated provider's 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 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.										

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 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.										

New 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 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.										
Task 5. Develop a post-acute network for the PPS community, including level of engagement										
Task 6. Develop a standardized protocol for integrated clinical teams to manage population health strategies of Care Transitions services from inpatient to discharge										
Task 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 8. Establish a best practice model of service utilizing a Coleman-like model of care transitions with participating providers and CBO's										
Task 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 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										

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
vulnerable populations in # 4 to expand capacity and competence to include "intensive care transitions coaches"										
Task 11. Present standardized protocols to appropriate Clinical Integration subcommittees and Clinical Integration and Quality Committee for formal adoption.										
Task 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 9-24-15: Remediation Response 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 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.										
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										

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
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.										
Task Required network social services, including medically tailored home food services, are provided in care transitions.										
Task 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. Submit strategies to project team and AFBHC leadership to review and for approval.										
Task 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 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 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 Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager										

New 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
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.	506	506	506	506	506	506	506	506	506	506
Task Policies and procedures are in place for early notification of planned discharges.	381	381	381	381	381	381	381	381	381	381
Task Policies and procedures are in place for early notification of planned discharges.	13	13	13	13	13	13	13	13	13	13
Task PPS has program in place that allows care managers access to visit patients in the hospital and provide care transition services and advisement.										
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										
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)										
Task 3. Clinical Integrated Teams will collaborate with the care transitions coach to coordinate identified high-risk needs post-acute hospitalization										
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.										
Task 5. Initiate steps identified in # 1, Step 7 utilizing teach back and/or return demonstration technique										
Task 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 7. Clinical Operations and Project Implementation teams will engage respective IT departments to review and modify any										

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
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 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 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.										
Task 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.										
Task 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 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 3. The Clinical Operations & Project Implementation team will survey participating providers to extract additional ideas surrounding timely notification of post-acute discharge dispositions										
Task 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 Ensure that a 30-day transition of care period is established.										
Task Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.										
Task 1. Eligible patients enrolled in a high risk readmission process for 30-days transitions period will be assigned a care transitions coach										
Task 2. The care transitions coach will establish a rapport with the										

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
patient and family by initiating contact about the Coleman-like Care Transitions Program through an initial hospital visit										
Task 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 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.										
Task 5. Track , measure and evaluate care transition programs effectiveness through data, feedback and outcomes, report through Clinical Integration and Quality committee										
Milestone #7 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 for Care Transitions project										
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.										
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										

New 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
short-term manual solutions										
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.										
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 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.	
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.	

New 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
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.	
Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	
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.	

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

Patient Update		% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
DY1, Q1	DY1,Q2			
0	0	0.00%	3,376	0.00%

Warning: Please note that your patients engaged to date does not meet your committed amount (3,376)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

Module Review Status

Review Status	IA Formal Comments
Fail	The PPS failed to meet at least 80% of its Actively Engaged commitments for 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)

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 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 Rapid Response Teams are facilitating hospital-home care collaboration, with procedures and protocols for: - discharge planning - discharge facilitation - 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 1. Identify project lead at PPS level	Project		In Progress	04/01/2015	11/30/2015	04/01/2015	11/30/2015	12/31/2015	DY1 Q3
Task 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	12/31/2015	12/31/2015	DY1 Q3
Task 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 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	12/31/2015	12/31/2015	DY1 Q3
Task 5. Complete a current state baseline of discharge processes, home care integration, palliative care and hospice involvement.	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 6. Define future state for the hospital to home-care collaboration	Project		In Progress	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)

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
programs with INTERACT-like techniques • Include collaboration during hospital visit to include home care liaison for greater acceptance of services being offered									
Task 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 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 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 10. Establish two way communication with hospital and home care that services have been initiated when patient discharged. • 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 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 Staff trained on care model, specific to: - patient risks for readmission - evidence-based preventive medicine - 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 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 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
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

New 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. 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 notify primary care physician of change in condition	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 3. Focus on care pathways with INTERACT-like tools on at home care level of recognition	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
• Acute mental status change • Changes in vital signs • Change in behavior • Observed change in fluid intake and output • Fever or change in temperature • Nausea, vomiting, diarrhea • Symptoms of lower respiratory illness • Symptoms of CHF • Symptoms of UTI									
Task 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 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 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 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 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 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 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 Training program for all home care staff established, which encompasses care pathways and INTERACT-like principles.	Provider	Home Care Facilities	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
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	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	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
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	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 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 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 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 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 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 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 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 Advance Care Planning tools incorporated into program (as evidenced by policies and procedures).	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
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	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
matter experts such as Hospice Teams to assist in educational sessions									
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 home care and Rapid Response Team staff.	Provider	Home Care Facilities	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
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

New 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. 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 the home environment	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
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	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
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.	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 and medication management.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
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	Project		In Progress	04/01/2016	03/31/2018	04/01/2016	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
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.	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
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	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
specialty expertise of PCPs and staff.									
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
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	Project		In Progress	04/01/2016	03/31/2018	04/01/2016	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
against these requirements									
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
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	Project		In Progress	01/01/2016	03/31/2018	01/01/2016	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
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	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 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. Monitor partnering sites that are unable to meet metrics and goals and develop process improving plan with AFBHC	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
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	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 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 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 Rapid Response Teams are facilitating hospital-home care collaboration, with procedures and protocols for:										

New 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
- discharge planning - discharge facilitation - confirmation of home care services										
Task 1. Identify project lead at PPS level										
Task 2. Form project implementation teams at each site, including case management and home care administrative and front line staff and PPS providers										
Task 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 4. Include existing Coleman trained care transitions coaches (CTC) to assist in development of discharge teams										
Task 5. Complete a current state baseline of discharge processes, home care integration, palliative care and hospice involvement.										
Task 6. Define future state for the hospital to home-care collaboration programs with INTERACT-like techniques • Include collaboration during hospital visit to include home care liaison for greater acceptance of services being offered										
Task 7. Integrate behavioral health concerns into process, including screening tools and appropriate referrals										
Task 8. Present recommendations and periodic updates to the Clinical Integration and Quality committee of the PPS on project methodology										
Task 9. Implement clinical guidelines for hospital discharges to home care services.										
Task 10. Establish two way communication with hospital and home care that services have been initiated when patient discharged. • 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..										

New 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 #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.										
Task Staff trained on care model, specific to: - patient risks for readmission - evidence-based preventive medicine - chronic disease management	0	0	0	0	1	2	3	5	5	5
Task Evidence-based guidelines for chronic-condition management implemented.										
Task 1. Asses current tools and educational offering utilized by home care staff for identification of changes in condition, chronic disease management, etc										
Task 2. Identify and obtain INTERACT-like tools that are needed to be used to educate home care										
Task 3. Determine resources needed for training, such as modules, train the trainer methods or direct education										
Task 4. Develop education plan and timeline for home care staff										
Task 5. Secure resources needed for training sessions, using INTERACT-like tools to supplement gaps in education needs										
Task 6. Train staff on chosen care model, focus on changes in patient condition, evidence based preventive medicine care coordination and chronic disease management										
Task 7. Document, track and aggregate evaluations of all training sessions using a learning management software (LMS) tool provided by the PPS.										
Task 8. Revise education methods as necessary to meet the needs of the participants										
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.										
Task Care pathways and clinical tool(s) created to monitor chronically-ill patients.										

New 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 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 1. Using INTERACT-like tools develop care pathways for home care to monitor chronically-ill patients										
Task 2. Through provider agreements, include guidance on when to notify primary care physician of change in condition										
Task 3. Focus on care pathways with INTERACT-like tools on at home care level of recognition • Acute mental status change • Changes in vital signs • Change in behavior • Observed change in fluid intake and output • Fever or change in temperature • Nausea, vomiting, diarrhea • Symptoms of lower respiratory illness • Symptoms of CHF • Symptoms of UTI										
Task 4. Work with IT resources through the PPS to help track 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										

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
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.										
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										

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
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										
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										

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 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 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.										

New 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. 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 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,										

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
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										
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.										

New 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. 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										
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										

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
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 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.										

New 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. 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 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.										

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 Assemble Rapid Response Teams (hospital/home care) 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
facilitate patient discharge to home and assure needed home care services are in place, including, if appropriate, hospice.										
Task Rapid Response Teams are facilitating hospital-home care collaboration, with procedures and protocols for: - discharge planning - discharge facilitation - confirmation of home care services										
Task 1. Identify project lead at PPS level										
Task 2. Form project implementation teams at each site, including case management and home care administrative and front line staff and PPS providers										
Task 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 4. Include existing Coleman trained care transitions coaches (CTC) to assist in development of discharge teams										
Task 5. Complete a current state baseline of discharge processes, home care integration, palliative care and hospice involvement.										
Task 6. Define future state for the hospital to home-care collaboration programs with INTERACT-like techniques • Include collaboration during hospital visit to include home care liaison for greater acceptance of services being offered										
Task 7. Integrate behavioral health concerns into process, including screening tools and appropriate referrals										
Task 8. Present recommendations and periodic updates to the Clinical Integration and Quality committee of the PPS on project methodology										
Task 9. Implement clinical guidelines for hospital discharges to home care services.										
Task 10. Establish two way communication with hospital and home care that services have been initiated when patient discharged.										

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
• 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 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 Staff trained on care model, specific to: - patient risks for readmission - evidence-based preventive medicine - chronic disease management	5	5	5	5	5	5	5	5	5	5
Task Evidence-based guidelines for chronic-condition management implemented.										
Task 1. Asses current tools and educational offering utilized by home care staff for identification of changes in condition, chronic disease management, etc										
Task 2. Identify and obtain INTERACT-like tools that are needed to be used to educate home care										
Task 3. Determine resources needed for training, such as modules, train the trainer methods or direct education										
Task 4. Develop education plan and timeline for home care staff										
Task 5. Secure resources needed for training sessions, using INTERACT-like tools to supplement gaps in education needs										
Task 6. Train staff on chosen care model, focus on changes in patient condition, evidence based preventive medicine care coordination and chronic disease management										
Task 7. Document, track and aggregate evaluations of all training sessions using a learning management software (LMS) tool provided by the PPS.										
Task 8. Revise education methods as necessary to meet the needs of the participants										
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.										

New 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 Care pathways and clinical tool(s) created to monitor chronically-ill patients.										
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.	12	12	12	12	12	12	12	12	12	12
Task 1. Using INTERACT-like tools develop care pathways for home care to monitor chronically-ill patients										
Task 2. Through provider agreements, include guidance on when to notify primary care physician of change in condition										
Task 3. Focus on care pathways with INTERACT-like tools on at home care level of recognition • Acute mental status change • Changes in vital signs • Change in behavior • Observed change in fluid intake and output • Fever or change in temperature • Nausea, vomiting, diarrhea • Symptoms of lower respiratory illness • Symptoms of CHF • Symptoms of UTI										
Task 4. Work with IT resources through the PPS to help track 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										

New 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
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.	5	5	5	5	5	5	5	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.										
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										

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
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										
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										

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
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 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.										

New 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 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 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										

New 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 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										
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										

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
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										
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										

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
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 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										

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
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 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.	
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

Patient Update		% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
DY1, Q1	DY1,Q2			
0	0	0.00%	447	0.00%

Warning: Please note that your patients engaged to date does not meet your committed amount (447)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

Module Review Status

Review Status	IA Formal Comments
Fail	The PPS failed to meet at least 80% of its Actively Engaged commitments for 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)

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		In Progress	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
Task	Project		In Progress	05/01/2015	03/31/2017	05/01/2015	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
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 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 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 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 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 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 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 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 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 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 Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach	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
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 Survey the targeted population about healthcare needs in the PPS' region.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Community engagement forums and other information-gathering	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
mechanisms established and performed.									
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 training. Continue to utilize volunteer PAM train the trainers to provide onsite training at provider sites.	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #6 Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP,	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
reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10). • 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. • 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 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 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 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 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.	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 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	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
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.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
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).	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 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 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 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 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 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 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	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 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 3. Utilize the AHRQ Working With Patient and Families as Advisers Implementation Handbook as a guide to develop a	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
training program for adviser roles in the PPS									
Milestone #9 Measure PAM(R) components, including: • 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. • 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. • Individual member's score must be averaged to calculate a baseline measure for that year's cohort. • The cohort must be followed for the entirety of the DSRIP program. • 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. • The PPS will NOT be responsible for assessing the patient via PAM(R) survey. • PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes. • 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 Performance measurement reports established, including but not limited to: - Number of patients screened, by engagement level - Number of clinicians trained in PAM(R) survey implementation - Number of patient: PCP bridges established - Number of patients identified, linked by MCOs to which they are associated - Member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis	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
- Member engagement lists to DOH (for NU & LU populations) on a monthly basis - Annual report assessing individual member and the overall cohort's level of engagement									
Task 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 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 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 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 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 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 Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
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	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
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 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
Task 9-24-15 Remediation Response 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 9-24-15 Remediation response 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 9-24-15 Remediation Response	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
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 9-24-15 Remediation Response 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 9-24-15 Remediation Response 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 9-24-15 Remediation Response 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 9-24-15 Remediation Response 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.	Project		In Progress	09/24/2015	03/31/2017	09/24/2015	03/31/2017	03/31/2017	DY2 Q4
Task 9-24-15 Remediation Response 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 9-24-15 Remediation Response 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

New 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 #12 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 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 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 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 9-24-15: Remediation Response 3. Policy and procedures for customer service complaints and appeals will be established & will, at a minimum, address the following key components: 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. 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.	Project		In Progress	09/24/2015	03/31/2017	09/24/2015	03/31/2017	03/31/2017	DY2 Q4
Task 9-24-15 Remediation Response: The compliance committee will track, aggregate & report complaints & resolutions & outcomes to the Project lead (s) and	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
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 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 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 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 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 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 Community navigators prominently placed (with high visibility) at appropriate locations within identified "hot spot" areas.	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. 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 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 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 9-24-15 Remediation Response	Project		In Progress	09/24/2015	03/31/2016	09/24/2015	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
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 9-24-15 Remediation Response 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 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 Navigators educated about insurance options and healthcare resources available to populations in this project.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
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	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
PCMH status and who have open access scheduling availability									
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 other technical platforms in the PPS against these requirements	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
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

New 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 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										
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.										
Task 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 Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.										
Task Patient Activation Measure(R) (PAM(R)) training team established.										
Task 1. PPS will contract with Insignia to provide PAM training on engaging target populations										

New 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. PPS will elicit volunteers from partners and CBO's to assign PAM "train the trainer" champions										
Task 3. Volunteer Champions will attend coordinated educational planning session with Insignia on July 16, 2015.										
Task 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 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 6. PPS Project 11 Manager will track individuals who attend Insignia PAM training and additional training sessions provided by Insignia										
Task 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 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										

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
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 mechanisms established and performed.										
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).										
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.										
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										
Milestone #5 Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.										
Task PPS Providers (located in "hot spot" areas) trained in patient activation techniques by "PAM(R) trainers".										
Task 1. Project Manager and Workforce Committee will develop educational tracking mechanisms to track all providers who										

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
receive training for reporting										
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.										
Task 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 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). • 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. • 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 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 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 2. Evaluate how each MCO determines PCP selection or assignment for their members										
Task 3. Coordinate & contract with the three leading Health Homes and downstream care coordination agencies, within our PPS, to										

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
assist with proactive outreach activities and administration of the PAM assessment tool.										
Task 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 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										

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
Advisers Implementation Handbook as a guide to develop a training program for adviser roles in the PPS										
Milestone #9 Measure PAM(R) components, including: • 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. • 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. • Individual member's score must be averaged to calculate a baseline measure for that year's cohort. • The cohort must be followed for the entirety of the DSRIP program. • 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. • The PPS will NOT be responsible for assessing the patient via PAM(R) survey. • PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes. • 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 Performance measurement reports established, including but not limited to: - Number of patients screened, by engagement level - Number of clinicians trained in PAM(R) survey implementation - Number of patient: PCP bridges established - Number of patients identified, linked by MCOs to which they are associated - Member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis - Member engagement lists to DOH (for NU & LU populations) on a monthly basis - Annual report assessing individual member and the overall cohort's level of engagement										
Task 1. Utilize information from the PAM admin tool to collect required										

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
information and training logs to report against required metrics.										
Task 2. Establish protocols and procedures for the community navigators to screen, assess, and administer the PAM® tool with eligible populations.										
Task 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 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 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 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 Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.										
Task Volume of non-emergent visits for UI, NU, and LU populations increased.										
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.										
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)										
Task 3. Identify providers with open scheduling and capacity to accept returning patients, new patients or who need specialized service such as dentistry.										
Task 4. Develop a referral process for community navigators to assess needs and link members to additional 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
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.										
Task Community navigators identified and contracted.	0	0	0	36	84	144	216	300	300	300
Task 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 1. Collaborate with AFBHC leadership and CBOs who provide navigation services to develop contracts for outreach and engagement activities.										
Task 2. Engage Workforce Committee to perform a gap analysis to determine workforce resources and training needs.										
Task 9-24-15 Remediation Response 3. Working with our community partners to develop strategies to identify or engage potential navigators who represent the populations served.										
Task 9-24-15 Remediation response 4. Develop a broad approach to train navigators to administer the PAM tool.										
Task 9-24-15 Remediation Response 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 9-24-15 Remediation Response 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 9-24-15 Remediation Response 7. Based on CNA and workforce analysis, develop a methodology for piloting the PAM tool rollout, placement of										

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
trained navigators and expectations of engagement numbers a targeted locations.										
Task 9-24-15 Remediation Response 8. Develop process to identify areas for roll out of PAM tool and placement of trained navigators.										
Task 9-24-15 Remediation Response 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 9-24-15 Remediation Response 10. Evaluate success of the program using workforce feedback, aggregation of engagment data and process improvements based on outcomes.										
Task 9-24-15 Remediation Response 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 Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.										
Task Policies and procedures for customer service complaints and appeals developed.										
Task 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 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 9-24-15: Remediation Response 3. Policy and procedures for customer service complaints and appeals will be established & will, at a minimum, address the										

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
following key components: 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. 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 9-24-15 Remediation Response: 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 Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).										
Task List of community navigators formally trained in the PAM(R).	0	0	0	36	84	144	216	300	300	300
Task 1. Community navigators embedded in "hot spots" will receive PAM® training through the PPS-wide training team (see requirement #2)										
Task 2. Mechanism for tracking training of community navigators will be developed with our IT consultants										
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.										
Task 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 1. Based on the "hot spot" data, AFBHC will identify and partner with CBOs and ensure a presence at community events in these areas										

New 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 feasibility of co-locating community navigators at established Navigator Agency sites that provide facilitated insurance enrollment										
Task 3. Create a directory (map) of sites where community navigators are located across the 6-county region										
Task 9-24-15 Remediation Response 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 9-24-15 Remediation Response 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 Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.										
Task Navigators educated about insurance options and healthcare 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										
Task 2. Educate navigators on the use of tools that will contain information on insurance options and healthcare resources										
Milestone #16 Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.										
Task Timely access for navigator when connecting members to 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 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 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 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 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 PPS identifies targeted patients through patient registries 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. Assess current EHR and 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.										
Task 3. Establish a process for monitoring project milestones and performance										
Task 4. Where electronic functionality is not yet ready, implement alternate in the interim and track conversion to electronic systems										
Task 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 Contract or partner with community-based organizations (CBOs)										

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
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										
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.										
Task 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 Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.										
Task Patient Activation Measure(R) (PAM(R)) training team established.										
Task 1. PPS will contract with Insignia to provide PAM training on engaging target populations										
Task 2. PPS will elicit volunteers from partners and CBO's to assign PAM "train the trainer" champions										

New 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. Volunteer Champions will attend coordinated educational planning session with Insignia on July 16, 2015.										
Task 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 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 6. PPS Project 11 Manager will track individuals who attend Insignia PAM training and additional training sessions provided by Insignia										
Task 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 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.										

New 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 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 mechanisms established and performed.										
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).										
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.										
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										
Milestone #5 Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.										
Task PPS Providers (located in "hot spot" areas) trained in patient activation techniques by "PAM(R) trainers".										
Task 1. Project Manager and Workforce Committee will develop educational tracking mechanisms to track all providers who receive training for 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)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,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.										
Task 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 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). • 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. • 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 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 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 2. Evaluate how each MCO determines PCP selection or assignment for their members										
Task 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.										

New 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 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 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										

New 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 #9 Measure PAM(R) components, including: • 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. • 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. • Individual member's score must be averaged to calculate a baseline measure for that year's cohort. • The cohort must be followed for the entirety of the DSRIP program. • 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. • The PPS will NOT be responsible for assessing the patient via PAM(R) survey. • PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes. • 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 Performance measurement reports established, including but not limited to: - Number of patients screened, by engagement level - Number of clinicians trained in PAM(R) survey implementation - Number of patient: PCP bridges established - Number of patients identified, linked by MCOs to which they are associated - Member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis - Member engagement lists to DOH (for NU & LU populations) on a monthly basis - Annual report assessing individual member and the overall cohort's level of engagement										
Task 1. Utilize information from the PAM admin tool to collect required information and training logs to report against required metrics.										

New 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. Establish protocols and procedures for the community navigators to screen, assess, and administer the PAM® tool with eligible populations.										
Task 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 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 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 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 Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.										
Task Volume of non-emergent visits for UI, NU, and LU populations increased.										
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.										
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)										
Task 3. Identify providers with open scheduling and capacity to accept returning patients, new patients or who need specialized service such as dentistry.										
Task 4. Develop a referral process for community navigators to assess needs and link members to additional service providers.										
Milestone #11 Contract or partner with CBOs to develop a group of 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
navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.										
Task Community navigators identified and contracted.	300	300	300	300	300	300	300	300	300	300
Task 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 1. Collaborate with AFBHC leadership and CBOs who provide navigation services to develop contracts for outreach and engagement activities.										
Task 2. Engage Workforce Committee to perform a gap analysis to determine workforce resources and training needs.										
Task 9-24-15 Remediation Response 3. Working with our community partners to develop strategies to identify or engage potential navigators who represent the populations served.										
Task 9-24-15 Remediation response 4. Develop a broad approach to train navigators to administer the PAM tool.										
Task 9-24-15 Remediation Response 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 9-24-15 Remediation Response 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 9-24-15 Remediation Response 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.										

New 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 9-24-15 Remediation Response 8. Develop process to identify areas for roll out of PAM tool and placement of trained navigators.										
Task 9-24-15 Remediation Response 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 9-24-15 Remediation Response 10. Evaluate success of the program using workforce feedback, aggregation of engagment data and process improvements based on outcomes.										
Task 9-24-15 Remediation Response 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 Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.										
Task Policies and procedures for customer service complaints and appeals developed.										
Task 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 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 9-24-15: Remediation Response 3. Policy and procedures for customer service complaints and appeals will be established & will, at a minimum, address the following key components: a. Members will have the availability to call the PPS, leave any										

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
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. 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 9-24-15 Remediation Response: 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 Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).										
Task List of community navigators formally trained in the PAM(R).	300	300	300	300	300	300	300	300	300	300
Task 1. Community navigators embedded in "hot spots" will receive PAM® training through the PPS-wide training team (see requirement #2)										
Task 2. Mechanism for tracking training of community navigators will be developed with our IT consultants										
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.										
Task 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 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 2. Assess feasibility of co-locating community navigators at established Navigator Agency sites that provide facilitated										

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
insurance enrollment										
Task 3. Create a directory (map) of sites where community navigators are located across the 6-county region										
Task 9-24-15 Remediation Response 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 9-24-15 Remediation Response 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 Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.										
Task Navigators educated about insurance options and healthcare 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										
Task 2. Educate navigators on the use of tools that will contain information on insurance options and healthcare resources										
Milestone #16 Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.										
Task Timely access for navigator when connecting members to services.										
Task 1. Identify PCP practices in the referring area that are in process										

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
of PCMH certification or have achieved NCQA 2014 Level 3 PCMH status and who have open access scheduling availability										
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										
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.										
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.										
Task PPS identifies targeted patients through patient registries 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. Assess current EHR and 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.										
Task 3. Establish a process for monitoring project milestones and performance										
Task 4. Where electronic functionality is not yet ready, implement alternate in the interim and track conversion to electronic systems										
Task 5. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS.										

Prescribed 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)

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). • 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. • 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.	
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.	

New 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
Measure PAM(R) components, including: • 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. • 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. • Individual member's score must be averaged to calculate a baseline measure for that year's cohort. • The cohort must be followed for the entirety of the DSRIP program. • 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. • The PPS will NOT be responsible for assessing the patient via PAM(R) survey. • PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes. • 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, 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).	

New 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
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	
Milestone #10	Pass & Ongoing	
Milestone #11	Pass & Ongoing	
Milestone #12	Pass & Ongoing	
Milestone #13	Pass & Ongoing	
Milestone #14	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 #15	Pass & Ongoing	
Milestone #16	Pass & Ongoing	
Milestone #17	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.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.d.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.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.

New 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.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

Patient Update		% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
DY1, Q1	DY1,Q2			
441	1,086	97.84%	24	1.89%

Warning: Please note that your patients engaged to date does not meet your committed amount (1,110)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
mccarrol	Documentation/Certification	3_null_1_2_20151028153549_DY1Q2_REGISTRY_2.b.iv.xlsx	DY1Q2 Patient Registry 3.a.i	10/28/2015 03:36 PM

Narrative Text :

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 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		In Progress	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		In Progress	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		In Progress	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	12/31/2015	12/31/2015	DY1 Q3
Task 5. Identify DSRIP project requirements, milestones (deliverable), and metrics and build these steps into the		Project		In Progress	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3

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
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	12/31/2015	12/31/2015	DY1 Q3
Task 7. Define future state of colocation of services		Project		In Progress	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
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 reimbursement and contracting, existing QI processes with compensation based on outcomes and any forays into alternate payment models		Project		In Progress	01/01/2016	03/31/2018	01/01/2016	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)	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 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 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 9-24-15 Remediation Response: 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 9-24-15 Remediation Response 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 9-24-15 Remediation Response 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 9-24-15 Remediation Response 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.		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)	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 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	12/31/2015	12/31/2015	DY1 Q3
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	12/31/2015	12/31/2015	DY1 Q3
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 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	07/03/2016	07/01/2015	07/03/2016	09/30/2016	DY2 Q2
Task 6. Document the workflow steps including		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	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
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.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
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		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 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 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 #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.	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 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 Screenings are documented in Electronic Health Record.		Project		In Progress	04/01/2015	03/30/2019	04/01/2015	03/30/2019	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		Provider	Practitioner - Primary	In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 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
health provider as measured by documentation in Electronic Health Record.			Care Provider (PCP)							
Task 1. Complete assessment to determine which preventive behavioral health screenings are currently used at each PCP sites		Project		In Progress	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 interventions		Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
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		Project		In Progress	03/01/2016	03/31/2019	03/01/2016	03/31/2019	03/31/2019	DY4 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
screenings										
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 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

New 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
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 Health practices and are available.		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 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		In Progress	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	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)	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 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	12/31/2015	12/31/2015	DY1 Q3
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	12/31/2015	12/31/2015	DY1 Q3
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	12/31/2015	12/31/2015	DY1 Q3
Task 6. Define future state of colocation of services		Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
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
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		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)	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
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.		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 (including generic work flow) to provide primary care within the BH settting in an integrated manner.		Project		In Progress	09/24/2015	03/31/2019	09/24/2015	03/31/2019	03/31/2019	DY4 Q4
Task 9-24-15 Remediation Response: 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 9-24-15 Remediation Response: 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

New 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
Task 9-24-15 Remediation Response 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 9-24-15 Remediation Response 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 9-24-15 Remediation Response 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 Develop collaborative evidence-based standards of care including medication management and care engagement process.	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 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	12/31/2015	12/31/2015	DY1 Q3
Task 2. Incorporate the identified standards and their sources		Project		In Progress	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)	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
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.		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
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

New 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
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 behavioral health screenings are currently used at each behavioral health services sites		Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
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-		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
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		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 indicated		Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
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		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)	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
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.		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
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

New 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
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
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		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
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.	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 engaged patients for project milestone reporting.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 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 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										

New 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 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 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										

New 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 15. Address any legal, financial and contractual issues, regulatory policies, waivers, licensure/certifications to provide co-location of services										
Task 16. Convene the project team to develop the collaborative care practices										
Task 9-24-15 Remediation Response: 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 9-24-15 Remediation Response 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 9-24-15 Remediation Response 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 9-24-15 Remediation Response 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 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.										
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.										

New 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 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										
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										

New 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 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.	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										

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
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 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										

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
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.	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.										

New 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 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 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,										

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
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.										
Task 9-24-15 Remediation Response: 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 9-24-15 Remediation Response: 20. Develop timeline for workforce recrutiment strategy. Incorporate CBOs as key stakeholders in model development and execution.										
Task 9-24-15 Remediation Response 21. Assess current state BH & SUD provider sites to identify opportunities to co-locate care and services using the Collaborative Care Model										
Task 9-24-15 Remediation Response 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 9-24-15 Remediation Response 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 Develop collaborative evidence-based standards of care including medication management and care engagement process.										
Task Regularly scheduled formal meetings are held to develop										

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
collaborative care practices.										
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process.										
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 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										

New 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 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.	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										

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 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 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										

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 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 #9 Implement IMPACT Model at Primary Care Sites.										
Task PPS has implemented IMPACT Model at Primary Care Sites.	0	0	0	0	0	0	0	0	0	0
Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.										
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.										
Task Policies and procedures include process for consulting with Psychiatrist.										
Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.										
Task PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records.										

New 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 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 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

New 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 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										
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										

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 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 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 15. Address any legal, financial and contractual issues, regulatory policies, waivers, licensure/certifications to provide co-location of services										
Task 16. Convene the project team to develop the collaborative care practices										
Task 9-24-15 Remediation Response: 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 9-24-15 Remediation Response 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 9-24-15 Remediation Response 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 9-24-15 Remediation Response 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.										

New 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 9-24-15 Remediation Response - Stakeholder Engagment: 21. While we have 35 providers committed, we have more behaviorist within the network to consider for implementation.										
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										

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
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, 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										

New 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 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										
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										

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
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.										
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 PCMH practices for the expected volume of patients and hours of										

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 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.										
Task 9-24-15 Remediation Response: 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 9-24-15 Remediation Response: 20. Develop timeline for workforce recrutiment strategy. Incorporate CBOs as key stakeholders in model development and execution.										
Task 9-24-15 Remediation Response 21. Assess current state BH & SUD provider sites to identify opportunities to co-locate care and services using the Collaborative Care Model										
Task 9-24-15 Remediation Response 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 9-24-15 Remediation Response										

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
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 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 a medication management and care engagement process.										
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 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										

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
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										
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										

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
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 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.										

New 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 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.										
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 #9 Implement IMPACT Model at Primary Care Sites.										
Task PPS has implemented IMPACT Model at Primary Care Sites.	0	0	0	0	0	0	0	0	0	0
Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.										
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.										

New 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 Policies and procedures include process for consulting with Psychiatrist.										
Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.										
Task PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records.										
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.										
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.										

New 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
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.	
Develop collaborative evidence-based standards of care including medication management and care engagement process.	
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.	
Develop collaborative evidence-based standards of care including medication management and care engagement process.	
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 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.	

New 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	
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

Patient Update		% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
DY1, Q1	DY1,Q2			
0	0	0.00%	509	0.00%

Warning: Please note that your patients engaged to date does not meet your committed amount (509)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

Module Review Status

Review Status	IA Formal Comments
Fail	The PPS failed to meet at least 80% of its Actively Engaged commitments for 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)

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		In Progress	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		In Progress	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	12/31/2015	12/31/2015	DY1 Q3
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	12/31/2015	12/31/2015	DY1 Q3
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	12/31/2015	12/31/2015	DY1 Q3
Task 6. Recognize any geographical gap in services within community based programs	Project		In Progress	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)

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. 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 18. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated	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
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	12/31/2015	12/31/2015	DY1 Q3
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	12/31/2015	12/31/2015	DY1 Q3
Task 3. Initiate and conduct regularly scheduled meetings with relevant agendas for identified stakeholders and representatives to develop and recommend evidence based practice models	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4. Collaborate with other project groups within the PPS project to	Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 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
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.	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 for use of buprenorphine and buprenorphine/naltrexone and other treatment modalities	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Recruit from existing network of stakeholders a project medical director as defined. Coordinate efforts with workforce	Project		In Progress	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)

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
strategies to widen search outside PPS provider network as necessary to recruit ideal candidate.									
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
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	Provider	Substance Abuse	In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 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
detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients.									
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 Staff are trained on community-based withdrawal management protocols and care coordination procedures.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Identify sites and practitioners that will participate in community withdrawal management services	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Convene project team with guidance from project medical director to review, select and apply protocols to designated	Project		In Progress	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)

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
programs									
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 management system (LMS) to include cultural aspects of care and health literacy issues focusing on withdrawal management, substance abuse & behavioral health.	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
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

New 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 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 of PPS best methods to track outcomes and revise as necessary	Project		In Progress	04/01/2016	09/30/2017	04/01/2016	09/30/2017	09/30/2017	DY3 Q2
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	Project		In Progress	04/01/2015	09/30/2016	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
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.	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 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	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
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	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 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										

New 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 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										
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										

New 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
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 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										

New 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 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.										
Task PPS has designated at least one qualified and certified physician with training and privileges for use of buprenorphine/Naltrexone and other withdrawal agents.										
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 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.										

New 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 3. Designate and retain contractually project medical director										
Task 4. Participate with PPS as project liaison between PPS, project team and other projects within the organization										
Task 5. Develop communication pathways for project medical director to guide project development, measure and report outcomes and initiate change if required.										
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.										
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	137	228	342	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.	0	0	0	0	0	0	97	162	243	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.	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 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										

New 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. 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 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										

New 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. 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.										
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										

New 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 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.										
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										

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
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.										
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 Develop community-based addiction treatment programs that include outpatient SUD sites with PCP integrated teams, and stabilization services including social 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 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										
Task 11. Align program with OASAS levels of 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 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.	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.										

New 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 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.										
Task PPS has designated at least one qualified and certified physician with training and privileges for use of buprenorphine/Naltrexone and other withdrawal agents.										

New 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 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 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 3. Designate and retain contractually project medical director										
Task 4. Participate with PPS as project liaison between PPS, project team and other projects within the organization										
Task 5. Develop communication pathways for project medical director to guide project development, measure and report outcomes and initiate change if required.										
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.										
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	95	95	95	95	95	95	95	95	95	95

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
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.	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										
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 community withdrawal management services										
Task 2. Convene project team with guidance from project medical director to review, select and apply protocols to designated programs										

New 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. 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.										
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										

New 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 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.										
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										

New 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
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 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.										

New 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 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 stabilization services including social services.	
Establish referral relationships between community treatment programs and inpatient detoxification services with development of referral protocols.	
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.	
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.	
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.	

New 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.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

Patient Update		% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
DY1, Q1	DY1,Q2			
0	0	0.00%	449	0.00%

Warning: Please note that your patients engaged to date does not meet your committed amount (449)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

Module Review Status

Review Status	IA Formal Comments
Fail	The PPS failed to meet at least 80% of its Actively Engaged commitments for 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)

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		In Progress	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		In Progress	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 7. Finalize Contract/MOUs with PCP practices and community	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 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
providers									
Task 8. Assess providers to determine current home based asthma programs, range of services provided, and referral mechanisms for identified patients.	Project		In Progress	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		In Progress	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 workforce into the community to enhance home assessments & follow ups.	Project		In Progress	09/24/2015	12/31/2016	09/24/2015	12/31/2016	12/31/2016	DY2 Q3
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
9-24-15 Remediation Response 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 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 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 1. Identify project lead and clinical support team for project potentially utilizing members from the project implementation groups	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Select procedures and intervention protocols for project	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3. Partner with resources such as the Asthma Coalition to fill in gaps if indicated	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 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	12/31/2015	12/31/2015	DY1 Q3
Task 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	12/31/2015	12/31/2015	DY1 Q3
Task 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
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

New 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 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
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	Project		In Progress	07/01/2016	03/31/2017	07/01/2016	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
of program quarterly									
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 asthma management and triggers with all providers	Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
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	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
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)	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 coordination team, including school nurses, pharmacists, CHW, dieticians, home care agency staff, environment agencies, state supported agencies, housing	Project		In Progress	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
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	Project		In Progress	09/01/2015	12/31/2016	09/01/2015	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
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.	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 Follow-up services implemented after ED or hospital visit occurs. Root cause analysis is conducted and shared with patient's family.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
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	12/31/2015	12/31/2015	DY1 Q3
Task 2. Finalize strategy for root cause analysis and teach back to	Project		In Progress	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
patient and/or family, with focus of use of asthma action plan									
Task 3. Identify IT solutions for event notifications to project teams	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
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 management. Include information from EMS in home/environmental assessments	Project		In Progress	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task 9-24-15 Remediation Response 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	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
9-24-15 Remediation Response 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 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 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 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 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 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 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 5. Finalize Contract/MOUs with MCOs at PPS level, specific to coverage of asthma health issue payments	Project		In Progress	03/31/2016	03/31/2018	03/31/2016	03/31/2018	03/31/2018	DY3 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	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
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. 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 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 Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.										
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.										
Task 1. Using CNA results and population health tools, hot spot asthma diagnoses in the covered 6 county region										
Task 2. Develop strategy to collaborate with neighboring PPS (see # 3 below) that selected projects asthma and tobacco use cessation projects										
Task 3. Identify opportunities for collaboration with neighboring PPS's such as Albany Medical Center & Adirondack Health Institute.										
Task 4. Integrate project plan components with PPS projects that influence outcomes and collaborate with surrounding communities and other PPS as necessary										
Task 5. Identify project lead at PPS level										
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										
Task 7. Finalize Contract/MOUs with PCP practices and community providers										
Task 8. Assess providers to determine current home based asthma programs, range of services provided, and referral mechanisms for identified patients.										
Task 9. Examine data to identify hot spotting areas for common asthma triggers in the identified population										
Task 10. Target areas for the project utilizing hot spotting and assessment.										
Task 11. Phase roll-out of project plans to coincide with in place 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)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task 12. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated										
Task 13. Finalize strategy for expanding home-based asthma self-management program										
Task 14. Implement clinical guidelines and processes										
Task 15. Track and evaluate programs roll out using rapid cycle team evaluation techniques										
Task 9-24-15 Remediation Response 16. Identify entities & agencies that will be implementing home based medical and social services, including current providers										
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.										
Task 9-24-15 Remediation Responses 18. Develop strategy for systematic rollout of home assessment workforce into the community to enhance home assessments & follow ups.										
Task 9-24-15 Remediation Response 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 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 PPS has developed intervention protocols and identified resources in the community to assist patients with needed evidence-based trigger reduction interventions.										
Task 1. Identify project lead and clinical support team for project potentially utilizing members from the project implementation groups										

New 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. Select procedures and intervention protocols for project										
Task 3. Partner with resources such as the Asthma Coalition to fill in gaps if indicated										
Task 4. Present recommendations to the Clinical Integration and Quality committee of the PPS on project methodology										
Task 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 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 7. Collaborate with the cultural competency & health literacy committee to establish age appropriate, culturally sensitive interventions to engage clients										
Task 8. Collaborate with the workforce committee to leverage workforce resources such as community health workers (CHW) to engage clients										
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)										
Milestone #3 Develop and implement evidence-based asthma management guidelines.										
Task PPS incorporates evidence-based guidelines that are periodically evaluated and revised, if necessary, in the design and implementation of asthma management.										
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										
Task 2. Submit clinical guideline recommendations to the Clinical Integration & Quality committee for approval										

New 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 3. Identify indoor trigger control guidelines from recognized entities such as the EPA and other environmental improvement agencies										
Task 4. Implement adopted guidelines into participating sites and providers.										
Task 5. Track and evaluate programs roll out using rapid cycle team evaluation techniques										
Task 6. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated										
Task 7. Communicate with asthma project providers level of success of program quarterly										
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.										
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.										
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										

New 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. 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.										
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										

New 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 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 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										

New 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 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 and revise objectives to improve outcomes when indicated										
Task 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 9-24-15 Remediation Response 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 9-24-15 Remediation Response 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 Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers,										

New 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
primary care providers, and specialty providers.										
Task 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 1. Identify from MCO's in the region if they offer asthma at home trigger reduction programs and self-management programs										
Task 2. Identify benefit offerings including covered drugs for asthma with protocols for their use										
Task 3. Compare AFBHC desired guidelines with health plan offerings and establish approach to increase or change coverage if required										
Task 4. Establish role of health plan, health home care managers, and primary care providers and include these roles in respective 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.										

New 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 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 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 Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.										
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.										
Task 1. Using CNA results and population health tools, hot spot asthma diagnoses in the covered 6 county region										
Task 2. Develop strategy to collaborate with neighboring PPS (see # 3										

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
below) that selected projects asthma and tobacco use cessation projects										
Task 3. Identify opportunities for collaboration with neighboring PPS's such as Albany Medical Center & Adirondack Health Institute.										
Task 4. Integrate project plan components with PPS projects that influence outcomes and collaborate with surrounding communities and other PPS as necessary										
Task 5. Identify project lead at PPS level										
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										
Task 7. Finalize Contract/MOUs with PCP practices and community providers										
Task 8. Assess providers to determine current home based asthma programs, range of services provided, and referral mechanisms for identified patients.										
Task 9. Examine data to identify hot spotting areas for common asthma triggers in the identified population										
Task 10. Target areas for the project utilizing hot spotting and assessment.										
Task 11. Phase roll-out of project plans to coincide with in place resources										
Task 12. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated										
Task 13. Finalize strategy for expanding home-based asthma self-management program										
Task 14. Implement clinical guidelines and processes										
Task 15. Track and evaluate programs roll out using rapid cycle team evaluation techniques										
Task 9-24-15 Remediation Response 16. Identify entities & agencies that will be implementing home										

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 medical and social services, including current providers										
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.										
Task 9-24-15 Remediation Responses 18. Develop strategy for systematic rollout of home assessment workforce into the community to enhance home assessments & follow ups.										
Task 9-24-15 Remediation Response 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 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 PPS has developed intervention protocols and identified resources in the community to assist patients with needed evidence-based trigger reduction interventions.										
Task 1. Identify project lead and clinical support team for project potentially utilizing members from the project implementation groups										
Task 2. Select procedures and intervention protocols for project										
Task 3. Partner with resources such as the Asthma Coalition to fill in gaps if indicated										
Task 4. Present recommendations to the Clinical Integration and Quality committee of the PPS on project methodology										
Task 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 6. Develop plans with the tobacco cessation project (4 b i) 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
reduce second hand smoke as an asthma trigger and connect engaged patients and families with tobacco cessation tools and education.										
Task 7. Collaborate with the cultural competency & health literacy committee to establish age appropriate, culturally sensitive interventions to engage clients										
Task 8. Collaborate with the workforce committee to leverage workforce resources such as community health workers (CHW) to engage clients										
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)										
Milestone #3 Develop and implement evidence-based asthma management guidelines.										
Task PPS incorporates evidence-based guidelines that are periodically evaluated and revised, if necessary, in the design and implementation of asthma management.										
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										
Task 2. Submit clinical guideline recommendations to the Clinical Integration & Quality committee for approval										
Task 3. Identify indoor trigger control guidelines from recognized entities such as the EPA and other environmental improvement agencies										
Task 4. Implement adopted guidelines into participating sites and providers.										
Task 5. Track and evaluate programs roll out using rapid cycle team evaluation techniques										
Task 6. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated										

New 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 7. Communicate with asthma project providers level of success of program quarterly										
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.										
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.										
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										

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
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.										
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										

New 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 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 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										

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

DSRIP Implementation Plan Project

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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 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 and revise objectives to improve outcomes when indicated										
Task 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 9-24-15 Remediation Response 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 9-24-15 Remediation Response 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 Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.										
Task 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 1. Identify from MCO's in the region if they offer asthma at home trigger reduction programs and self-management programs										
Task 2. Identify benefit offerings including covered drugs for asthma with protocols for their use										
Task 3. Compare AFBHC desired guidelines with health plan offerings										

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

DSRIP Implementation Plan Project

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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 establish approach to increase or change coverage if required										
Task 4. Establish role of health plan, health home care managers, and primary care providers and include these roles in respective 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.										

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

DSRIP Implementation Plan Project

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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 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
Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.	
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.	
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	

New 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
what happened and how to avoid future events.	
Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.	
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

Patient Update		% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
DY1, Q1	DY1,Q2			
114	236	81.94%	52	1.45%

Warning: Please note that your patients engaged to date does not meet your committed amount (288)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
mccarrol	Documentation/Certification	3_null_1_2_20151028153741_DY1Q2_REGISTRY_3.g.i.xlsx	DY1Q2 Patient Registry 3.g.i	10/28/2015 03:38 PM

Narrative Text :

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 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		In Progress	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	12/31/2015	12/31/2015	DY1 Q3
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
Task	Project		In Progress	07/01/2015	01/31/2017	07/01/2015	01/31/2017	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
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 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 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 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 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 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 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 3. PPS will survey participating sites to determine current state for offering/providing palliative care services and the expectation	Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 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
to enhance existing services									
Task 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 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 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 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 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 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 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 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	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	03/31/2017	09/01/2015	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
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 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
Task 10. Collaborate with Cultural Competency and Health Literacy Taskforce to incorporate age appropriate clinical guidelines and ensure care pathways encompass patient and family cultural	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
competency and health literacy aspects.									
Milestone #4 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 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 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 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 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 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 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 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
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	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
coverage of palliative care supports and services.									
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 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 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	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
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	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 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 received agreement from those PCPs not PCMH and/or APCM	0	0	0	0	0	0	0	61	142	243

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
certified to become certified to at least Level 1 of the 2014 NCQA PCMH and/or APCM by Demonstration Year 3.										
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.										
Task 2. PPS Operations Team will execute contract/MOU's with participating sites, CBO's and other identified providers										
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										
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										
Task 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 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 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 Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.										
Task 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 1. PPS will develop BAA's, MOUs, & provider agreements with CBO's and hospice to assist in obtaining medical provider										

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
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 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 3. PPS will survey participating sites to determine current state for offering/providing palliative care services and the expectation to enhance existing services										
Task 4. The PPS & Workforce Committee will conduct and assess the current state to determine potential workforce needs										
Task 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 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 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 Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.										
Task 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 1. The Clinical Operations Team will complete a current 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
assessment of which PCP practices are currently utilizing the MOLST form.										
Task 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 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 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 5. Collaborate with the practitioner engagement task force and practicing sites to identify a physician and/or provider champion.										
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/)										
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										
Task 8. Each practice site "champion" will be paired with a Palliative Care subject matter expert and receive mentoring and education to integrate services										
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										
Task 10. Collaborate with Cultural Competency and Health Literacy Taskforce to incorporate age appropriate clinical guidelines 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
ensure care pathways encompass patient and family cultural competency and health literacy aspects.										
Milestone #4 Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.										
Task Staff has received appropriate palliative care skills training, including training on PPS care protocols.										
Task 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 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 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 4. Introduce a 'train the trainer' approach through "Respecting Choices" for prompting and holding conversations leading to advance directives discussions										
Task 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 6. Track training competency through LMS system										
Milestone #5 Engage with Medicaid Managed Care to address coverage of services.										
Task PPS has established agreements with MCOs that address the coverage of palliative care supports and services.										
Task 1. Review AFBHC adopted palliative care guidelines with Medicaid and Medicare MCOs in the region.										

New 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. 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 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 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 Use EHRs or other IT 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 Step 1: Determine requirements for identification of targeted patients and tracking actively engaged patients per state-provided specifications for the DSRIP program										
Task Step 2: Review strategies and tools needed to promote DSRIP specific Patient Engagement for palliative care										
Task 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 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										

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 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 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.	364	506	506	506	506	506	506	506	506	506
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.										
Task 2. PPS Operations Team will execute contract/MOU's with participating sites, CBO's and other identified providers										
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										

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
obtain Level 3 NCQA certification who are participating in this project										
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										
Task 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 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 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 Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.										
Task 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 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 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 3. PPS will survey participating sites to determine current state										

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
for offering/providing palliative care services and the expectation to enhance existing services										
Task 4. The PPS & Workforce Committee will conduct and assess the current state to determine potential workforce needs										
Task 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 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 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 Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.										
Task 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 1. The Clinical Operations Team will complete a current state assessment of which PCP practices are currently utilizing the MOLST form.										
Task 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 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.										

New 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 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 5. Collaborate with the practitioner engagement task force and practicing sites to identify a physician and/or provider champion.										
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/)										
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										
Task 8. Each practice site "champion" will be paired with a Palliative Care subject matter expert and receive mentoring and education to integrate services										
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										
Task 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 Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.										
Task Staff has received appropriate palliative care skills training, including training on PPS care protocols.										
Task 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.										

New 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. 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 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 4. Introduce a 'train the trainer' approach through "Respecting Choices" for prompting and holding conversations leading to advance directives discussions										
Task 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 6. Track training competency through LMS system										
Milestone #5 Engage with Medicaid Managed Care to address coverage of services.										
Task PPS has established agreements with MCOs that address the coverage of palliative care supports and services.										
Task 1. Review AFBHC adopted palliative care guidelines with Medicaid and Medicare MCOs in the region.										
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										
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.										
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.										

New 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 #6 Use EHRs or other IT 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 Step 1: Determine requirements for identification of targeted patients and tracking actively engaged patients per state-provided specifications for the DSRIP program										
Task Step 2: Review strategies and tools needed to promote DSRIP specific Patient Engagement for palliative care										
Task 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 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										

New 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 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.	
Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.	
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	

New 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 & 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 specialist/educators, etc.)	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
Task 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 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 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 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 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 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 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 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	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
Task 6. Create a Collaborative Care Model in	In Progress	6. Create a Collaborative Care Model in identified Primary Care and	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
identified Primary Care and Behavioral Health practices		Behavioral Health practices						
Milestone 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 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 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 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 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 9-24-15 Remediation Response 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 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 9-24-15 Remediation Response 6. Quarterly outcome dashboards measuring certain metrics and consumer engagement results will be developed and reported to project teams, Clinical Integration and Quality	In Progress	9-24-15 Remediation Response 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	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
committee and governance committees to track outcomes including satisfaction levels and adjust program methods, if required								
Milestone 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 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 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 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

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Participate in MEB health promotion and MEB disorder prevention partnerships.	

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)

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
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 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 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 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 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	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

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
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 healthcare education on tobacco cessation strategies	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
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
Task 5. Review, revise and align policies, procedures and guidelines for completing the	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

New 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
5 A's across the PPS.								
Milestone 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 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 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 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 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 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 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
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

New 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 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 monitor actions or side effects of co-morbid conditions or medications. Collaborative with 3 a i Project Team.	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
Task 5. In collaboration with health plans,	In Progress	5. In collaboration with health plans, appropriate practitioner types, CBOs, and state health agencies develop specific strategies to	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 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
appropriate practitioner types, CBOs, and state health agencies develop specific strategies to increase benefit use rate by population segments that underutilize services		increase benefit use rate by population segments that underutilize services						
Milestone 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 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 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 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 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

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
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:	12/15/2015 01:53 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, Q2	Adjudicated	Bethany Panzirer gilboard	sv590918	12/31/2015 09:20 PM
DY1, Q2	Submitted	Bethany Panzirer gilboard	cpoe2008	12/15/2015 01:53 PM
DY1, Q2	Returned	Bethany Panzirer gilboard	emcgill	12/01/2015 12:24 PM
DY1, Q2	Submitted	Bethany Panzirer gilboard	cpoe2008	10/28/2015 04:39 PM
DY1, Q2	In Process		ETL	10/01/2015 12:14 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)

Comments Log			
Status	**Comments**	**User ID**	**Date Timestamp**
Returned	DY1 Q2 Quarterly Report has been returned for remediation.	emcgill	12/01/2015 12:24 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
	IPQR Module 4.3 - Major Risks to Implementation & Risk Mitigation Strategies	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 4.4 - 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
	IPQR Module 7.6 - Key Stakeholders	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 7.7 - 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
	IPQR Module 10.8 - 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	Status
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	
	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
	IPQR Module 3.a.i.4 - 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)

Project ID	Module Name	Status
	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 & Ongoing	
	Module 1.5 - Prescribed Milestones		
	Milestone #1	Pass & Ongoing	
Section 02	Module 2.1 - Prescribed Milestones		
	Milestone #1	Pass (with Exception) & Complete	
	Milestone #2	Pass & Ongoing	
	Milestone #3	Pass & Complete	
	Milestone #4	Pass & Ongoing	
	Milestone #5	Pass & Ongoing	
	Milestone #6	Pass & Ongoing	
	Milestone #7	Pass & Ongoing	
	Milestone #8	Pass & Ongoing	
	Milestone #9	Pass & Ongoing	
Section 03	Module 3.1 - Prescribed Milestones		
	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)

Section	Module Name / Milestone #	Review Status	
	Milestone #8	Pass & Ongoing	
Section 04	Module 4.1 - Prescribed Milestones		
	Milestone #1	Pass & Ongoing	
	Milestone #2	Pass & Ongoing	
Section 05	Module 5.1 - Prescribed Milestones		
	Milestone #1	Pass & Ongoing	
	Milestone #2	Pass & Ongoing	
	Milestone #3	Pass & Ongoing	
	Milestone #4	Pass & Ongoing	
	Milestone #5	Pass & Ongoing	
Section 06	Module 6.1 - Prescribed Milestones		
	Milestone #1	Pass & Ongoing	
	Milestone #2	Pass & Ongoing	
Section 07	Module 7.1 - Prescribed Milestones		
	Milestone #1	Pass & Ongoing	
	Milestone #2	Pass & Ongoing	
Section 08	Module 8.1 - Prescribed Milestones		
	Milestone #1	Pass & Ongoing	
	Milestone #2	Pass & Ongoing	
Section 09	Module 9.1 - Prescribed Milestones		
	Milestone #1	Pass & Ongoing	
	Milestone #2	Pass & Ongoing	
Section 11	Module 11.2 - Prescribed Milestones		
	Milestone #1	Pass & Ongoing	
	Milestone #2	Pass & Ongoing	
	Milestone #3	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)

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	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)

Project ID	Module Name / Milestone #	Review Status	
2.a.i	Module 2.a.i.2 - Prescribed Milestones		
	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	
2.b.iii	Module 2.b.iii.2 - Patient Engagement Speed	Fail	
	Module 2.b.iii.3 - Prescribed Milestones		
	Milestone #1	Pass & Ongoing	
	Milestone #2	Pass & Ongoing	
	Milestone #3	Pass & Ongoing	
	Milestone #4	Pass & Ongoing	
	Milestone #5	Pass & Ongoing	
2.b.iv	Module 2.b.iv.2 - Patient Engagement Speed	Fail	
	Module 2.b.iv.3 - Prescribed Milestones		
	Milestone #1	Pass & Ongoing	
	Milestone #2	Pass & Ongoing	
	Milestone #3	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)

Project ID	Module Name / Milestone #	Review Status	
	Milestone #4	Pass & Ongoing	
	Milestone #5	Pass & Ongoing	
	Milestone #6	Pass & Ongoing	
	Milestone #7	Pass & Ongoing	
2.b.viii	Module 2.b.viii.2 - Patient Engagement Speed	Fail	
	Module 2.b.viii.3 - Prescribed Milestones		
	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	
2.d.i	Module 2.d.i.2 - Patient Engagement Speed	Fail	
	Module 2.d.i.3 - Prescribed Milestones		
	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)

Project ID	Module Name / Milestone #	Review Status	
	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	
	Milestone #16	Pass & Ongoing	
	Milestone #17	Pass & Ongoing	
3.a.i	Module 3.a.i.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.a.i.3 - Prescribed Milestones		
	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	

New 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 / Milestone #	Review Status	
	Milestone #14	Pass & Ongoing	
	Milestone #15	Pass & Ongoing	
3.a.iv	Module 3.a.iv.2 - Patient Engagement Speed	Fail	
	Module 3.a.iv.3 - Prescribed Milestones		
	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	
3.d.ii	Module 3.d.ii.2 - Patient Engagement Speed	Fail	
	Module 3.d.ii.3 - Prescribed Milestones		
	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	
3.g.i	Module 3.g.i.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.g.i.3 - Prescribed Milestones		
	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)

Project ID	Module Name / Milestone #	Review Status	
	Milestone #3	Pass & Ongoing	
	Milestone #4	Pass & Ongoing	
	Milestone #5	Pass & Ongoing	
	Milestone #6	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	