ADVOCATE COMMUNITY PROVIDERS

WORKFORCE TRANSITION ROADMAP

DEPARTMENT OF WORKFORCE,
COMMUNITY, AND GOVERNMENT RELATIONS

PREPARED IN COLLABORATION WITH

CHWS
Center for Health Workforce Studies

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Transition Roadmap Overview

As part of the NYS DOH Medicaid Redesign Team's Delivery System Reform Incentive Payment (DSRIP) program, Advocate Community Providers (ACP) Performing Provider System (PPS) developed a workforce transition roadmap based on the current state of the workforce, the target state and the gap analysis.

In accordance with its Workforce Implementation Plan, ACP completed this roadmap by carefully conducting a:

- Detailed comparison of positions and competencies across each of the four sectors: ACP PPS, medical practices, community-based organizations, and hospitals, for the ten DSRIP projects
- Action plan to assist its network Primary Care Providers to obtain National Committee for Quality Assurance (NCQA) 2014 Patient-Centered Medical Home (PCMH) Level 3 Certifications

ACP engaged the Center for Workforce Studies (CHWS) in Albany as its workforce vendor and subject matter expert. CHWS is widely recognized in NYS as one of the most important thought leaders in the study of the workforce in healthcare. In collaboration with CHWS, ACP completed the current workforce state, target workforce state, gap analysis, and transition roadmap.

In collaboration with CHWS, ACP conducted an in-depth analysis of the requirements of each project in order to determine any changes to the new service delivery structure of the PPS. This was completed through a systematic organizational assessment that determined the project-by-project impact on the workforce of each of the four sectors: hospitals, physicians, community-based organizations, and ACP PPS. This assessment examined the projects' objectives, strategies, workforce implications and workforce environmental constraints to derive the occupation specific implications on each sector, therefore, spelling out the projects' target workforce state for each one and guidelines to mitigate workforce gaps, which constitutes the foundation for the transition roadmap.

In order grasp the transition roadmap findings, it is important to read this report in conjunction with the current workforce state, target workforce state, and gap analysis documents.

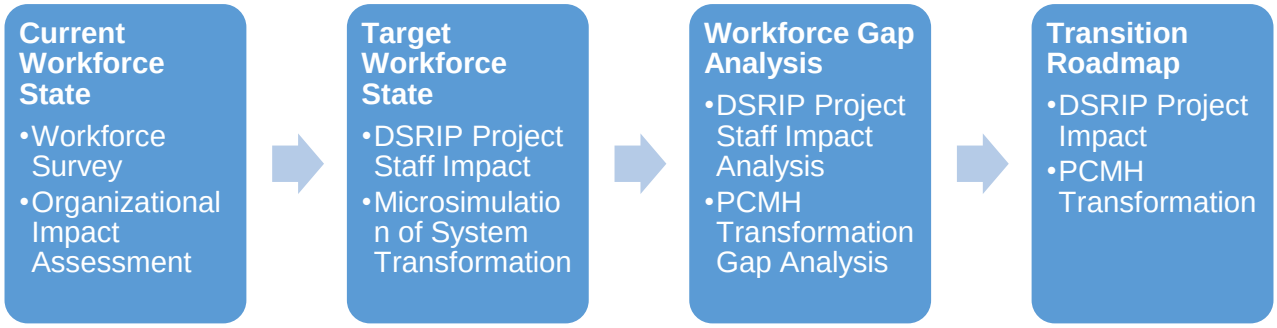
The transition roadmap was prepared by the Department of Workforce, Community, and Government Relations and included input from partnering entities through the Workforce Advisory Committee and Steering Committee.

The Board of Directors approved the document.

Developing the Transition Roadmap

ACP engaged the Center for Workforce Studies (CHWS) in Albany as its workforce vendor and subject matter expert. CHWS is widely recognized in NYS as one of the most important thought leaders in the study of the workforce in healthcare. In collaboration with CHWS, ACP completed the current workforce state, target workforce state, gap analysis, and transition roadmap.

The flowchart below illustrates the sequential tasks in the development of this document.



ACP Project Workforce State Analysis

The gap analysis identified specific workforce needs by the ten different ACP projects, please see separate report. The first step in the process is to understand how the strategies for each of the ten projects impact on the workforce. ACP project staff, along with ACP management and CHWS subject matter expert reviewed each of the projects in detail and identified specific implementation strategies based on the toolkit provided by the New York State Department of Health and on other evidenced-based literature.

Once project strategies were documented, a systematic organizational assessment determined the project-by-project impact that those strategies would have on the health care workforce, specifically, what would the health care staff need to do or know to implement the strategy. The implications were broken out by facility type, i.e., hospitals, medical practices, community-based organizations, and ACP staff. Implications could include training and/or hiring new staff to accomplish these new roles. As indicated previously, however, workforce environmental constraints must be identified, understanding that current shortages could impact on ACP's ability to ultimately implement projects.

Given the significant staff overlap among the ten projects, the transition roadmap translates the individual project workforce needs into one coherent plan that lays out a training plan.

Patient-Centered Medical Home Transformation

A key component of the health care transformation under DSRIP is the provision of high quality primary care for all Medicaid recipients, and uninsured, including children and high needs patients. The National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) and Advanced Primary Care models are transformative, with strong focus on evidence based practice, population management, coordination of care, HIT integration, and

practice efficiency. Such practices will be imperative as the health care system transforms to a focus on community based services.

ACP will facilitate and assist in this certification process by addressing those providers who were not otherwise eligible for support in this practice advancement as well as those programs with multiple sites that wish to undergo a rapid transformation. The end result of this transformation will be that 748 providers in 560 practices within the ACP performing provider system must meet NCQA 2014 Level 3 PCMH accreditation and/or meet state-determined criteria for Advanced Primary Care Models before December 31, 2017, and successfully sustain that practice model with improvement in monitored quality improvement metrics through the end of DSRIP.

ACP Project Requirements

ACP Project Requirement Analysis: 2.a.i Integrated Delivery Systems				
Project Manager: John Dionisio				
Overall objective: Create Integrated Delivery Systems that are focused on Evidence-Based Medicine/ Population Health Management				
	Hospitals	**Medical Practices**	**CBOs**	**ACP PPS**
Objectives	Reduce avoidable ED visits and hospitalizations of ACP attributed patients defined as potentially preventable admissions (PPAs) and potentially preventable readmissions (PPRs).	PCPs to achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models.	Work with ACP to address needs, including social services, of eligible ACP attributed patients.	Insure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services. Leverage health homes (HHs)/ACOs/IPAs support when possible.
	Insure 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.	Insure that EHR systems used by participating safety net providers meet Meaningful Use (MU) standards by the end of DY 3.	Develop technical integration strategies to allow for easier data sharing.	Insure 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.
		Insure 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.		Develop and manage overall VBP strategy.
Strategies	Identify ACP attributed patients who are hospitalized or visit the ED through EHR information exchange platforms (RHIOs) and/or patient navigators (PNs).	Identify person who will monitor PCMH certification progress and make use of ACP PCMH content expert and vendors.	Establish referral process with ACP to meet the needs of eligible ACP attributed patients.	Carry out a community needs assessment, workforce survey, IT needs and requirement assessment, clinical workflow survey, and financial sustainability survey.
	Facilitate the implementation of ACP's system transformation projects to insure that patients who are hospitalized or visit the ED visit their PCP, and that Health Home at-risk patients, PPA and PPRs are identified, properly referred, and monitored.	Refer eligible patients to ACP's supporting staff for team-based care: Care Managers, Care Coordinators, and Community Health Workers.	Address ACP attributed patients' community needs by establishing partnerships with NYC public agencies.	Utilize partnering HHs, ACOs, and IPAs population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.
	Collaborate with Medicaid Managed Care Organizations (MCOs) regarding data sharing to help with patient identification process.	Make use of ACP provided centralized EHR systems to formulate more effective care plans and allow for consistent clinical data streams, funding PCMH designation, and subsidizing RHIO connectivity fees.	Assist ACP by identifying services and point of contact person for the development of a comprehensive ACP community resource guide.	Facilitate contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements
	Insure that appropriate communication occurs regarding VBP initiatives that target hospitals.	Continue to serve ACP attributed patients in their language and with the cultural sensitivity that characterizes the ACP network.		Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers. Reinforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.
		Insure that appropriate communication occurs regarding VBP initiatives that target medical practices.		Facilitate PCMH level 3 certification process through the work of ACP's PCMH level 3 content expert and vendors.
				Provide ACP medical practices with access to ACP staff: Care Managers, Care Coordinators, and CHWs to help better manage the health of the neediest ACP attributed patients.
				Develop a comprehensive ACP community resource guide.
				Provide appropriate technological tools to ACP staff to deploy strategic initiatives (i.e. tablets, hardware, and software).
Workforce Implications	Hire patient navigators (PNs) to work in ACP network hospitals.	Train medical practice staff on EHR systems, and ACP care management/coordination patient eligibility guidelines and referral process.	Educate staff of involved CBOs and public agencies on ACP PPS and integrated delivery systems project.	Hire project manager.
	Place ACP Community Health Workers (CHWs) in ACP hospitals' EDs.	Educate medical practice staff to make use of ACP resources for PCMH level 3 certification, Care Coordination and Care Management.		Hire and train Value-Based/Medical Economics Analyst, Data Scientists, IDS Specialist/IT Coordinators, ACP CHWs, Care Managers, and Care Coordinators.
	Train PNs and CHWs on eligibility guidelines, referral process, electronic patient tracker, RHIOs and HIE.	Educate medical practice staff on ACP resources to facilitate VBP transition.		Hire and train ACP PCMH level 3 content experts and other PCMH support staff.
				Develop ACP core team for VBP to address network preparedness.
Workforce Environment/ Constraints	Role of ACP CHWs spread throughout all projects.	Limited number and availability of medical practice staff.	Potential resistance of out of network CBOs and NYC public agencies to establish partnerships with ACP.	Role of ACP CHWs spread throughout projects.
	Potential resistance of hospitals to hire enough PNs.	Potential resistance to refer patients to ACP Care Managers and Care Coordinators.		Limited number and availability of ACP PCMH level 3 content experts and other supporting staff.
	Leverage existing workforce with hospital MCOs, clinics to avoid work duplication.			High cost and limited availability of complete clinical/technical integration in the market.
Occupational specific redeployment, training, and hiring	Hire CHWs and PNs.	Educate medical practice staff on ACP resources for PCMH level 3 certification.	Offer training to CBOs and public agency staff on ACP PPS and integrated delivery systems project.	Hire ACP project manager, PCMH level 3 content experts, Care Coordinators, Care Managers, and CHWs.
	Train CHWs and PNs on project, patient eligibility guidelines, referral process, and technology tools used for patient tracking and engagement.	Train medical practice staff on project, patient eligibility guidelines, and referral process.		Certify PCMH level 3 content manager experts and PCMH support staff.
				Analysts to complete *Data Analytics* training at the General Assembly Campus in New York City.
				Train Care Coordinators, Care Managers, and CHWs on IDS.

ACP Project Requirement Analysis: 2.a.iii Health Home at-risk Intervention

Project Manager: Indiana Maskhulia

Overall objective: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services

	Hospitals	Medical Practices	CBOs	ACP PPS
Objectives	Reduce avoidable ED visits and hospitalizations of ACP attributed patients defined as potentially preventable admissions (PPAs) and potentially preventable readmissions (PPRs).	Take the lead in supporting health home at-risk projects and patients.	Work with ACP to address needs, including social services, of eligible ACP attributed patients.	Develop integrated delivery services to reach overall project's goal, and reduce avoidable hospitalizations and ED visits.
		PCPs to achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models.		Insure that health home at risk eligible patients are receiving the proper care management services.
		Equip medical practice staff to properly implement project.		
Strategies	Identify ACP attributed patients who are hospitalized or visit the ED through EHR information exchange platforms (RHIOs) and/or patient navigators (PNs).	Implement ACP's proper project procedures and protocols to provide total PCMH level 3 care.	Establish referral process with ACP to meet the needs of eligible ACP attributed patients and establish ongoing communication.	Through partnership and guidance of health homes develop evidence-based procedures and protocols to engage eligible ACP attributed patients and reduce these events.
	Facilitate the implementation of ACP's system transformation projects to insure that patients who are hospitalized or visit the ED visit their PCP, and that Health Home at-risk patients, PPA and PPRs are identified, properly referred, and monitored.	Provide eligible at-risk patients comprehensive care plan, and refer eligible at-risk patients to ACP's Care Managers and Care Coordinators.	Address ACP attributed patients' community needs by establishing partnerships with NYC public agencies.	Carry out a community needs assessment, workforce survey, IT needs and requirement assesment, clinical workflow survey, and financial sustainability survey.
	Collaborate with Medicaid Managed Care Organizations (MCOs) regarding data sharing to help with patient identification process.	PCP, or lead provider, to develop a practice culture that supports patient selt-management.	Assist ACP by identifying services and point of contact person for the developmenf of a comprehensive ACP community resource guide.	Develop a comprehensive ACP community resource guide.
		Assist in identifying leaders and participants for ACP Stanford Model self-management workshops.		Integrate cultural competency and health literacy strategy to insure efficient communication and proper development of materials (for patient education and workforce training).
		Insure that coordination of stakeholders (i.e. health homes) is timely and accurate.		Provide ACP medical practices with access to ACP staff: Care Managers, Care Coordinators, and CHWs.
		Continue to serve ACP attributed patients in their language and with the cultural sensitivity that characterizes the ACP network.		Facilitate PCMH level 3 certification process through the work of ACP's PCMH level 3 content expert and vendors.
Workforce Implications	Hire patient navigators (PNs) to work in ACP network hospitals.	Train medical practice staff on project, patient eligibility guidelines, and referral process.	Educate staff of involved CBOs and public agencies on ACP PPS and project.	Hire and train project manager.
	Place ACP Community Health Workers (CHWs) in ACP hospitals' EDs.	Educate medical practice staff to make use of ACP resources for PCMH level 3 certification, Care Coordination and Care Management.	Place selected CHWs in CBOs in higher needs communities.	Hire and train ACP CHWs, Care Managers, and Care Coordinators.
	Train PNs and CHWs on eligibility guidelines, referral process, and technology tools used for patient engagement.			Hire and train ACP PCMH level 3 content experts and other PCMH support staff.
Workforce Environment/ Constraints	Role of ACP CHWs spread throughout projects.	Limited number and availability of medical practice staff.	Potential resistance of out of network CBOs and NYC public agencies to establish partnerships with ACP.	Role of ACP CHWs spread throughout projects.
	Potential resistance of hospitals to hire enough PNs.	Potential resistance to refer patients to health homes or ACP Care Managers and Care Coordinators.		Limited number and availability of ACP Care Managers, Care Coordinators, PCMH level 3 content expert, and other PCMH support staff.
	Leverage existing workforce with hospital MCOs, clinics to avoid work duplication.			
Occupational specific redeployment, training, and hiring	Hire CHWs and PNs.	Educate medical practice staff on ACP resources for PCMH level 3 certification.	Offer training to CBOs and public agency staff on ACP PPS and project.	Hire project manager, PCMH level 3 content experts, other PCMH support staff, Care Coordinators, Care Managers, and CHWs.
	Train CHWs and PNs on project, patient eligibility guidelines, referral process, and technology tools used for patient engagement.	Train medical practice staff on project, patient eligibility guidelines, and referral process.		Certify PCMH level 3 content manager experts.
				Project manager to complete online *Master Certificate in Applied Project Management-Healthcare* through Villanova University.
				Project managers received NCQA HEDIS training.
				Train Care Coordinators, Care Managers, CHWs, and others on project protocols ACP community resource guide, Stanford Model, and Coleman transition of care models.

ACP Project Requirement Analysis: 2.b.iii ED care triage for at-risk populations

Project Manager: Sarah Tobey (consultant)

Objective: to develop an evidence-based care coordination and transitional care program that will assist patients to link with a primary care physician/practitioner, support patient confidence in understanding and self-management of personal condition(s), improve provider to provider communication, and provide supportive assistance to transitioning members to the least restrictive environment.

	Hospitals	Medical Practices	CBOs	ACP PPS
Objectives	Decrease unnecessary use of the emergency room (ED) by effectively linking patients with primary care providers (PCPs) and improving provider to provider communications.	PCPs to achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models.	Work with ACP to address needs, including social services, of eligible patients.	Insure that patients who seek non-urgent services in the ED are linked to a PCP, therefore receiving proper care and decreasing unnecessary use of the ED.
	Reduce avoidable ED visits and hospitalizations of ACP attributed patients defined as potentially preventable admissions (PPAs) and potentially preventable readmissions (PPRs).	Collaborate with ACP and participating emergency departments (EDs) to get patients who visit the ED an appointment with their PCP with an emphasis on PCMH Level 3 certified practitioners.		Assist in PCPs' PCMH level 3 certification process.
Strategies	Collaborate with ACP in establishing linkages to PCPs with emphasis on those who are PCMH level 3 certified.	PCMH level 3 certified PCPs will work with ACP to develop a process of connectivity between the ED and PCP to provide open access scheduling and extended hours.	Establish referral process with ACP to meet the needs of eligible patients.	Develop project protocol, guidelines, and scheduling process for PCP appointments.
	Connect frequent ED users with the PCMH providers available to them.	Make use of ACP provided centralized EHR systems to formulate more effective care plans and allow for consistent clinical data streams, funding PCMH designation, and subsidizing RHIO connectivity fees.	Assist ACP by identifying services and point of contact person for the development of a comprehensive ACP community resource guide.	Establish linkages between EDs and PCPs, especially those that are PCMH level 3 certified, and insure effective provider to provider communication.
	Notify ACP, PCP, and Health Home care manager if applicable, about patients' ED visit and transmit triage information for the patient to PCP.	Continue to serve ACP attributed patients in their language and with the cultural sensitivity that characterizes the ACP network.	Provide services to ACP referred patients in their language when possible and with cultural competency.	Facilitate the process to connect frequent ED users with the PCMH providers available to them.
	Assist non-emergency patients, once required medical screening examination is performed, in receiving an immediate appointment with their PCP or finding an appropriate one if needed.	Make use of ACP team-based care staff for patient engagement, i.e. CHWs, care managers/care coordinators, to support care and promote self-management.		Develop infrastructure and connectivity necessary to facility secured communication among all stakeholders, i.e. ED, Health Homes, PNs, CHWs, and PCPs.
	Integrate ACP cultural competency and health literacy strategy to insure efficient communication and patient engagement, and promote self-management.	Collaborate with ACP in improving provider to provider communications.		Provide ACP medical practices with access to ACP staff: Care Managers, Care Coordinators, and CHWs to help better manage the health of the neediest ACP attributed patients.
	Collaborate with ACP in developing the infrastructure and connectivity needed to facilitate secured communication among all stakeholders, i.e. ED, patient navigator (PN), community health workers (CHWs), and PCPs.			Develop a comprehensive ACP community resource guide.
	Collaborate with ACP in emphasizing the value of having a PCP.			Provide appropriate technological tools to ACP staff to deploy strategic initiatives (i.e. tablets, hardware, and software).
				Integrate ACP CCHL strategy to insure efficient communication and patient engagement, and promote self-management.
Workforce Implications	Hire patient navigators (PNs) to work in ACP network hospitals.	Train medical practice staff on EHR systems, ACP care management/coordination patient eligibility guidelines and referral process, and ED triage project.	Educate staff of involved CBOs and public agencies on ACP PPS and project.	Hire project manager.
	Place ACP Community Health Workers (CHWs) in ACP hospitals' EDs.	Educate medical practice staff to make use of ACP resources for PCMH level 3 certification, Care Coordination and Care Management.		Hire and train Data Scientists, IDS Specialist/IT Coordinators, ACP CHWs, Care Managers, and Care Coordinators.
	Train PNs and CHWs on guidelines, referral process, electronic patient tracker, RHIOs, HIE, patient consultation, and provider education.			Hire and train ACP PCMH level 3 content experts and other PCMH support staff.
Workforce Environment/ Constraints	Role of ACP CHWs spread throughout all projects.	Limited number and availability of medical practice staff.	Potential resistance of out of network CBOs and NYC public agencies to establish partnerships with ACP.	Role of ACP CHWs spread throughout projects.
	Potential resistance of hospitals to hire enough PNs.	Potential resistance to refer patients to ACP Care Managers and Care Coordinators.		Limited number and availability of ACP PCMH level 3 content experts and other supporting staff.
				High cost and limited availability of complete clinical/technical integration in the market.
Occupational specific redeployment, training, and hiring	Hire CHWs and PNs.	Educate medical practice staff on ACP resources for PCMH level 3 certification and supporting staff.	Offer training to CBOs and public agency staff on ACP PPS, project, and CCHL.	Hire ACP project manager, PCMH level 3 content experts, Care Coordinators, Care Managers, and CHWs.
	Train CHWs and PNs on project, guidelines, referral process, technology tools used for patient tracking and engagement, cultural competency and health literacy (CCHL), patient consultation, and provider education.	Train medical practice staff, clinical and administrative, on project, patient eligibility guidelines, referral process, and CCHL.		Certify PCMH level 3 content manager experts and PCMH support staff.
				Train CHWs, care coordinators, care managers, and other appropriate staff on project, guidelines, patient consultation, provider education, technology tools, CCHL, and metrics.

ACP Project Requirement Analysis: 2.b.iv Implementation of Care Coordination and Transitional Care Programs

Project Manager: TBD

To provide a 30 day supported transition period after a hospitalization to ensure discharge directions are understood and implemented by the patients at high risk of readmission, particularly those with cardia, renal, diabetes, respiratory, and/or behavioral health disorders.

	Hospitals	Medical Practices	CBOs	ACP PPS
Objectives	Decrease unnecessary 30-day hospital readmissions for chronic health conditions by effectively improving patient health literacy and provider to provider communications.	PCPs to achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models.	Work with ACP to address needs, including social services, of eligible patients.	Insure that patients who are hospitalized receive clear, culturally sensitive discharge instructions, and the support needed to avoid readminissions for chronic health conditions.
	Reduce avoidable ED visits and hospitalizations of ACP attributed patients defined as potentially preventable admissions (PPAs) and potentially preventable readmissions (PPRs).	Collaborate with ACP and participating hospitals to get patients who are hospitalized supported transition care by connecting them with their PCP.		Assist in PCPs' PCMH level 3 certification process.
Strategies	Collaborate with ACP in developing discharge regiments that integrate ACP cultural compentency and health literacy strategy to insure that patients understand and comply with directions and promote self-management.	Make use of ACP provided centralized EHR systems to formulate more effective care plans and allow for consistent clinical data streams, funding PCMH designation, and subsidizing RHIO connectivity fees.	Establish referral process with ACP to meet the needs of eligible patients.	Develop project protocol, guidelines, and care transition protocol.
	Collaborate with Medicaid Managed Care Organizations (MCOs) regarding data sharing to help with patient identification process and to develop transition of care protocols.	Continue to serve ACP attributed patients in their language and with the cultural sensitivity that characterizes the ACP network.	Assist ACP by identifying services and point of contact person for the development of a comprehensive ACP community resource guide.	Establish linkages among hospitals, PCPs, Medicaid Managed Care Organizations (MCOs), and Health Homes regarding data sharing to help with patient identification process and to develop transition of care protocols.
	Collaborate with ACP in developing the infrastructure and connectivity needed to facilitate secured communication among all stakeholders, i.e. hospital, patient navigator (PN), community health workers (CHWs), and PCPs.	Make use of ACP team-based care staff for patient engagement, i.e. CHWs, care managers/care coordinators, to support care and promote self-management.	Provide services to ACP referred patients in their language when possible and with cultural competency.	Develop infrastructure and connectivity necessary to facility secured communication among all stakeholders, i.e. hospital, Health Homes, PNs, CHWs, and PCPs.
	Collaborate with ACP in emphasizing the value of having a PCP.	Collaborate with ACP in improving provider to provider communications.	Collaborate with ACP in identifying community-based resources for patients post-hospitalization.	Provide ACP medical practices with access to ACP staff: Care Managers, Care Coordinators, and CHWs to help better manage the health of the neediest ACP attributed patients.
	Engage with ACP, Health Homes, and MCOs to develop transition of care protocols that insure they are followed properly.			Develop a comprehensive ACP community resource guide.
	Work with ACP to make available community-based support and resources for patients post-hospitalization.			Provide appropriate technological tools to ACP staff to deploy strategic initiatives (i.e. tablets, hardware, and software).
	Notify ACP, PCP, and Health Home care manager if applicable, about patients' admission and transmit discharge information for the patient to PCP.			Integrate ACP CCHL strategy to insure efficient communication and patient engagement, and promote self-management.
Workforce Implications	Hire patient navigators (PNs) to work in ACP network hospitals.	Train medical practice staff on EHR systems, ACP care management/coordination patient eligibility guidelines and referral process, and care transition project.	Educate staff of involved CBOs and public agencies on ACP PPS and project.	Hire project manager.
	Place ACP Community Health Workers (CHWs) in ACP hospitals' EDs.	Educate medical practice staff to make use of ACP resources for PCMH level 3 certification, Care Coordination and Care Management.		Hire and train Data Scientists, IDS Specialist/IT Coordinators, ACP CHWs, Care Managers, and Care Coordinators.
	Train PNs and CHWs on guidelines, referral process, electronic patient tracker, RHIOs, HIE, patient consultation, and provider education.			Hire and train ACP PCMH level 3 content experts and other PCMH support staff.
Workforce Environment/ Constraints	Role of ACP CHWs spread throughout all projects.	Limited number and availability of medical practice staff.	Potential resistance of out of network CBOs and NYC public agencies to establish partnerships with ACP.	Role of ACP CHWs spread throughout projects.
	Potential resistance of hospitals to hire enough PNs.	Potential resistance to refer patients to ACP Care Managers and Care Coordinators.		Limited number and availability of ACP PCMH level 3 content experts and other supporting staff.
				High cost and limited availability of complete clinical/technical integration in the market.
Occupational specific redeployment, training, and hiring	Hire CHWs and PNs.	Educate medical practice staff on ACP resources for PCMH level 3 certification and supporting staff.	Offer training to CBOs and public agency staff on ACP PPS, project, and CCHL.	Hire ACP project manager, PCMH level 3 content experts, Care Coordinators, Care Managers, and CHWs.
	Train CHWs and PNs on project, guidelines, referral process, technology tools used for patient tracking and engagement, cultural competency and health literacy (CCHL), patient consultation, and provider education.	Train medical practice staff, clinical and administrative, on project, patient eligibility guidelines, referral process, and CCHL.		Certify PCMH level 3 content manager experts and PCMH support staff.
				Train CHWs, care coordinators, care managers, and other appropriate staff on project, guidelines, patient consultation, provider education, technology tools, CCHL, and metrics.

ACP Project Requirement Analysis: 3.a.i Integration of Primary Care & Behavioral Health

Project Manager: Gabriel Rosario

Overall objective: Integration of mental health and substance abuse with primary care services to ensure coordination of care for both services.

	Hospitals	Medical Practices	CBOs	ACP PPS
Objectives	Reduce avoidable ED visits and hospitalizations of ACP attributed patients struggling with behavioral health and substance use issues.	Provide collaborative team-based care to ACP attributed patient through implementation of the project's three models: integrate behavioral health services into the PC settings, integrate PC services into behavioral health sites, and implement IMPACT into independent PCP practices.	Provide collaborative team-based care to ACP attributed patient through implementation of the project's three models: integrate behavioral health services into the PC settings, integrate PC services into behavioral health sites, and implement IMPACT into independent PCP practices.	Provide collaborative team-based care to ACP attributed patient through implementation of the project's three models: integrate behavioral health services into the PC settings, integrate PC services into behavioral health sites, and implement IMPACT into independent PCP practices.
		Create patient-centered model with PCPs and behavioral health providers working together to provide quality holistic healthcare.	Work with ACP to address needs, including social services, of eligible ACP attributed patients.	Assist medical practices in understanding behavioral health issues and coordinating care of behavioral health patients
		PCPs to achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models.		Create patient-centered model with PCPs and behavioral health providers working together to provide quality holistic healthcare.
Strategies	Identify ACP attributed patients with a behavioral health diagnosis who are hospitalized or visit the ED EHR information exchange platforms (RHIOs) and/or patient navigators (PNs).	Implement ACP-developed standardized protocols through EHRs that include screening and treatment for depression, substance use, as well as referrals for other serious psychiatric conditions (i.e. schizophrenia).	Address ACP attributed patients' community needs by establishing partnerships with NYC public agencies.	Create standardized protocols to be implemented across ACP network through EHRs that include screening and treatment for depression, substance use, as well as referral for other serious psychiatric conditions, e.g. schizophrenia.
	Implement system transformation projects' protocols to insure that behavioral health and substance use patients who are hospitalized in an ACP network hospital or visit the ED see their PCP, and that Health Home at-risk patients, PPA and PPRs are identified, properly referred, and monitored.	Coordinate with ACP's behavioral health partners and in-network hospitals to allow for warm handoffs to effectively and efficiently coordinate care.	Increase linkages between health care and CBOs for behavioral health patients	Team up with OMH and the University of Washington's AIMS Center to participate in a pilot for the IMPACT Model implementation to carefully review, deliberate, and receive guidance, coaching, and training on the IMPACT Model and the use of behavioral health care managers.
	Coordinate with ACP's behavioral health partners and PCPs to allow for warm handoffs to effectively and efficiently coordinate care.	Continue to serve ACP attributed patients in their language and with the cultural sensitivity that characterizes the ACP network.	Increase identification and use of alcohol and substance use peer support groups	Contract and designate consulting psychiatrists for implementation of the IMPACT model's collaborative care process (model 3).
	Collaborate with mental health clinics at hospitals for the implementation of models 1 and 2.	Implement ACP's proper project procedures and protocols to provide total PCMH level 3 care.	Assist ACP by identifying services and point of contact person for the development of a comprehensive ACP community resource guide.	Collaborate with the New York City OMH and Regional Planning Consortium to share lessons learned amongst the statewide PPSs to incorporate best practices and achieve desired outcomes.
				Collaborate with the State and City OMH in developing a comprehensive evidence-based SBIRT training for our PCPs and team.
				Assist behavioral health partners in attaining and implementing PC services.
				Develop relationships with alcohol and substance use support groups to provide community-based resources to help patients with ongoing needs.
				Develop a comprehensive ACP community resource guide.
				Establish roving interdisciplinary teams.
				Integrate cultural competency and health literacy strategy to insure efficient communication and proper development of materials (for patient education and workforce training).
				Facilitate PCMH level 3 certification process through the work of ACP's PCMH level 3 content expert and vendors.
Workforce Implications	Hire patient PNs and Behavioral Health (BH) Managers to work in ACP network hospitals.	Train medical practice staff on project protocols, training materials on performing evidence-based assessments such as PHQ2/9, DAST, and AUDIT C, collaborative care, care coordination, and referral process.	Increase the number of peer support groups support behavioral health patients and substance use disorder.	Hire and train project manager.
	Place ACP Community Health Workers (CHWs) in ACP hospitals' EDs.	Train medical staff for IMPACT model implementation.	Educate staff of involved CBOs and public agencies on ACP PPS, and project protocols.	Hire physician engagement teams for deployment to PCP practices to distribute protocols and easy-to-follow training materials on performing evidence-based assessments such as PHQ2/9, DAST, and AUDIT C by integrating these into the EHRs and incorporating these into the everyday workflow.
	Train PNs, BH Managers, and CHWs on eligibility guidelines, referral process, and technology tools used for patient engagement.	Educate medical practice staff to make use of ACP resources for PCMH level 3 certification, Care Coordination and Care Management.		Hire and train ACP CHWs, Care Managers, Care Coordinators, PCMH level 3 content experts, and other PCMH support staff.
Workforce Environment/ Constraints	Role of ACP CHWs spread throughout projects.	Increased use of medical assistants in private practices.	Potential resistance of out of network CBOs and NYC public agencies to establish partnerships with ACP.	Role of ACP CHWs spread throughout projects.
	Potential resistance of hospitals to hire PNs.	Limited resources and space.		Limited number and availability of ACP Care Managers, Care Coordinators, PCMH level 3 content expert, and other PCMH support staff.
	Leverage existing workforce with hospital MCOs, clinics to avoid work duplication.			
Occupational specific redeployment, training, and hiring	Hiring of PNs.	Train medical practice staff on project protocols, IMPACT Model, training materials on performing evidence-based assessments such as PHQ2/9, DAST, and AUDIT C, collaborative care, care coordination, referral process, and ACP community resource guide.	Offer training to CBOs and public agency staff on ACP PPS, project, and referral process.	Hire project manager, PCMH level 3 content experts, PCMH support staff, Care Coordinators, Care Managers, and CHWs.
	Train CHWs and PNs on project, patient eligibility guidelines, referral process, and technology tools used for patient engagement.			Certify PCMH level 3 content manager experts.
				Project manager to complete online *Master Certificate in Applied Project Management-Healthcare* through Villanova University.
				Project managers received NCQA HEDIS training.
				Train Care Coordinators, Care Managers, CHWs, and others on project protocols ACP community resource guide, Stanford Model, and Coleman transition of care models.

ACP Project Requirement Analysis: 3.b.i Cardiovascular Disease Management

Project Manager: Shariff De Los Santos

Overall objective: To support implementation of evidence-based best practices for disease management in medical practice for adults with cardiovascular conditions (adults only).

	Hospitals	Medical Practices	CBOs	ACP PPS
Objectives	Reduce avoidable ED visits and hospitalizations of ACP attributed patients with a cardiovascular disease diagnosis.	PCPs to achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models.	Support ACP attributed patients to increase cardiovascular disease self-managing and self-efficacy for prevention and disease control.	Insure ACP network medical practices and ambulatory care setting use evidence-based strategies to improve management of cardiovascular disease.
		Promote cardiovascular disease patient education to increase self-efficacy and self-management.	Work with ACP to address needs, including social services, of eligible ACP attributed patients.	
		Equip medical practice staff to properly implement project.		
Strategies	Identify ACP attributed patients with a cardiovascular disease diagnosis who are hospitalized or visit the ED through EHR information exchange platforms (RHIOs) and/or patient navigators (PNs).	Implement ACP's project protocol and provide total PCMH level 3 care.	Establish referral process with ACP to meet the needs of eligible ACP attributed patients.	Carry out a community needs assessment and cardiovascular disease prevalence 'hotspot' analysis,
	Implement system transformation projects' protocols to insure that cardiovascular disease patients who are hospitalized in an ACP network hospital or visit their ED visit their PCP, and that Health Home at-risk patients, PPA and PPRs are identified, properly referred, and monitored.	Promote cardiovascular disease patient education to increase self-efficacy and self-management through care plans, LSM counseling, and the use of ACP-produced language appropriate, culturally sensitive educational material on cardiovascular disease.	Address ACP attributed patients' community needs by establishing partnerships with NYC public agencies, and out of network CBOs.	Engage cardiovascular disease specialists and PCPs, identify and track cardiovascular disease patients with emphasis on "hotspots."
		Assist in identifying leaders and participants for ACP Stanford Model self-management workshops.	Collaborate with ACP to host/facilitate Stanford Model workshop sites.	Develop proper procedures and protocols to engage eligible ACP attributed patients and reduce avoidable ED visits and hospitalizations.
		Refer eligible cardiovascular disease patients to ACP's Care Managers and Care Coordinators.	Assist ACP by identifying services and point of contact person for the development of a comprehensive ACP community resource guide.	Develop a comprehensive ACP community resource guide.
		Collaborate with ACP CHWs in ACP attributed patient outreach for eligible cardiovascular disease patients.		Establish roving interdisciplinary teams.
		Implement Million Hearts campaign strategies.		Integrate cultural competency and health literacy strategy to insure efficient communication and proper development of materials (for patient education and workforce training).
		Establish 'blood pressure stations' in each practice for patients to measure their blood pressure free of charge and without an appointment.		Facilitate PCMH level 3 certification process through the work of ACP's PCMH level 3 content expert and vendors.
		Continue to serve ACP attributed patients in their language and with the cultural sensitivity that characterizes the ACP network.		Provide Care Management and Care Coordination to eligible ACP attributed patients.
Workforce Implications	Hire patient PNs to work in ACP network hospitals.	Train medical practice staff on project, cardiovascular disease care plans, Million Hearts campaign, blood pressure station, and referral process.	Educate staff of involved CBOs and public agencies on ACP PPS, project, and Stanford Model.	Hire and train project manager.
	Place ACP Community Health Workers (CHWs) in ACP hospitals' EDs.	Collaborate with ACP CHWs in ACP attributed patient outreach for eligible cardiovascular disease patients.		Hire and train ACP CHWs, Care Managers, Care Coordinators, PCMH level 3 content expert, and other PCMH support staff.
	Train PNs and CHWs on eligibility guidelines, referral process, and electronic patient tracker.	Educate medical practice staff to make use of ACP resources for PCMH level 3 certification, Care Coordination and Care Management.		
Workforce Environment/ Constraints	Role of ACP CHWs spread throughout projects.	Increased use of medical assistants in private practices.	Potential resistance of out of network CBOs and NYC public agencies to establish partnerships with ACP.	Limited number and availability of ACP Care Managers, Care Coordinators, PCMH level 3 content expert, and other PCMH support staff.
	Potential resistance of hospitals to hire PNs.	Limited resources and space.		Role of ACP CHWs spread throughout projects.
Occupational specific redeployment, training, and hiring	Hiring of PNs.	Train Medical Assistants, or appropriate staff identified by PCP or practice lead, on project, referral process, Million Hearts campaign, blood pressure station, and ACP community resource guide.	Offer training to CBOs and public agency staff on ACP PPS and project.	Hire project manager, PCMH level 3 content experts, other PCMH support staff, Care Coordinators, Care Managers, and CHWs.
	Train CHWs and PNs on project, patient eligibility guidelines, referral process, and technology tools used for patient engagement.			Project manager to complete online *Master Certificate in Applied Project Management-Healthcare* through Villanova University.
				Certify PCMH level 3 content manager expert.
				Project managers received NCQA HEDIS training.
				Train Care Coordinators, Care Managers, CHWs, and others on project protocols ACP community resource guide, Stanford Model, and Coleman transition of care models.

ACP Project Requirement Analysis: 3.c.i Diabetes Disease Management

Project Manager: Li Guo

Overall objective: To support implementation of evidence-based best practices for disease management in medical practice (adult only).

	Hospitals	Medical Practices	CBOs	ACP PPS
Objectives	Reduce avoidable ED visits and hospitalizations of ACP attributed patients with a diabetes diagnosis.	PCPs to achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models.	Support ACP attributed patients to increase diabetes self-managing and self-efficacy for disease control.	Insure ACP network medical practices and ambulatory care setting use evidence-based strategies to improve management of diabetes.
		Promote diabetes patient education to increase self-efficacy and self-management.	Work with ACP to address needs, including social services, of eligible ACP attributed patients.	
		Equip medical practice staff to properly implement project.		
Strategies	Identify ACP attributed patients who are hospitalized or visit the ED through EHR information exchange platforms (RHIOs) and/or patient navigators (PNs).	Implement ACP's project protocol and provide total PCMH level 3 care.	Establish referral process with ACP to meet the needs of eligible ACP attributed patients.	Carry out a community needs assessment and diabetes prevalence 'hotspot' analysis.
	Implement system transformation projects' protocols to insure that ACP attributed patients who are hospitalized in an ACP network hospital or visit their ED visit their PCP, and that Health Home at-risk patients, PPA and PPRs are identified, properly referred, and monitored.	Promote diabetes patient education to increase self-efficacy and self-management through care plans, LSM counseling, and the use of -produced language appropriate, culturally sensitive educational material on diabetes.	Address ACP attributed patients' community needs by establishing partnerships with NYC public agencies, and out of network CBOs.	Engage diabetes specialists and PCPs, identify and track diabetic patients with emphasis on "hotspots."
		Assist in identifying leaders and participants for ACP Stanford Model self-management workshops.	Collaborate with ACP to host/facilitate Stanford Model workshop sites.	Develop proper procedures and protocols to engage eligible ACP attributed patients and reduce avoidable ED visits and hospitalizations.
		Refer eligible diabetic patients to ACP's Care Managers and Care Coordinators.	Assist ACP by identifying services and point of contact person for the development of a comprehensive ACP community resource guide.	Develop a comprehensive ACP community resource guide.
		Collaborate with ACP CHWs in ACP attributed patient outreach for eligible diabetic patients.		Establish roving interdisciplinary teams.
		Continue to serve ACP attributed patients in their language and with the cultural sensitivity that characterizes the ACP network.		Integrate cultural competency and health literacy strategy to insure efficient communication and proper development of materials (for patient education and workforce training).
				Facilitate PCMH level 3 certification process through the work of ACP's PCMH level 3 content expert and vendors.
				Provide Care Management and Care Coordination to eligible ACP attributed patients.
Workforce Implications	Hire patient PNs to work in ACP network hospitals.	Train medical practice staff on project, diabetes care plans, and referral process.	Educate staff of involved CBOs and public agencies on ACP PPS, project, and Stanford Model.	Hire and train project manager.
	Place ACP Community Health Workers (CHWs) in ACP hospitals' EDs.	Educate medical practice staff to make use of ACP resources for PCMH level 3 certification, Care Coordination and Care Management.		Hire and train ACP CHWs, Care Managers, Care Coordinators, PCMH level 3 content expert, and other PCMH support staff.
	Train PNs and CHWs on eligibility guidelines, referral process, and electronic patient tracker.			
Workforce Environment/ Constraints	Role of ACP CHWs spread throughout projects.	Increased use of medical assistants in private practices.	Potential resistance of out of network CBOs and NYC public agencies to establish partnerships with ACP.	Limited number and availability of ACP Care Managers, Care Coordinators, PCMH level 3 content expert, and other PCMH support staff.
	Potential resistance of hospitals to hire PNs.	Limited resources.		Role of ACP CHWs spread throughout projects.
Occupational specific redeployment, training, and hiring	Hiring of PNs.	Train Medical Assistants, or appropriate staff identified by PCP or practice lead, on project, referral process, and ACP community resource guide.	Offer training to CBOs and public agency staff on ACP PPS and project protocol.	Hire project manager, PCMH level 3 content experts, other PCMH support staff, Care Coordinators, Care Managers, and CHWs.
	Train CHWs and PNs on project, patient eligibility guidelines, referral process, and technology tools used for patient engagement.			Project manager to complete online *Master Certificate in Applied Project Management-Healthcare* through Villanova University.
				Certify PCMH level 3 content manager expert.
				Project managers received NCQA HEDIS training.
				Train Care Coordinators, Care Managers, CHWs, and others on project protocols ACP community resource guide, Stanford Model, and Coleman transition of care models.

ACP Project Requirement Analysis: 3.d.iii: Asthma

Project Manager: Maria Debes

Overall objective: To ensure access for all patients with asthma to care consistent with evidence-based medicine guidelines for asthma management.

	Hospitals	Medical Practices	CBOs	ACP PPS
Objectives	Reduce avoidable ED visits and hospitalizations of ACP attributed patients with an asthma diagnosis.	PCPs to achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models.	Support ACP attributed patients to increase asthma self-management and self-efficacy to control condition and prevent visits to ED.	Address asthma management issues related to compliance with clinical asthma practice guidelines and lack of access to pulmonary and allergy specialists in New York City.
		Promote asthma patient education to increase self-efficacy and self-management.	Work with ACP to address needs, including social services, of eligible ACP attributed patients.	
		Equip medical practice staff to properly implement project.		
Strategies	Identify ACP attributed patients with an asthma diagnosis who are hospitalized or visit the ED through EHR information exchange platforms (RHIOs) and/or patient navigators (PNs).	Implement ACP's project protocol and provide total PCMH level 3 care.	Establish referral process with ACP to meet the needs of eligible ACP attributed patients.	Carry out a community needs assessment and asthma prevalence 'hotspot' analysis.
	Implement system transformation projects' protocols to insure that asthmatic patients who are hospitalized in an ACP network hospital or visit their ED visit their PCP, and that Health Home at-risk patients, PPA and PPRs are identified, properly referred, and monitored.	Promote asthma patient education to increase self-efficacy and self-management through care plans, LSM counseling, and the use of ACP-produced language appropriate, culturally sensitive educational material on asthma.	Address ACP attributed patients' community needs by establishing partnerships with NYC public agencies, and out of network CBOs.	Engage asthma specialists and PCPs, identify and track asthmatic patients with emphasis on "hotspots."
		Assist in identifying leaders and participants for ACP Stanford Model self-management workshops.	Collaborate with ACP to host/facilitate Stanford Model workshop sites.	Develop proper procedures and protocols to engage eligible ACP attributed patients and reduce avoidable ED visits and hospitalizations.
		Refer eligible asthmatic patients to ACP's Care Managers and Care Coordinators.	Assist ACP by identifying services and point of contact person for the development of a comprehensive ACP community resource guide.	Establish roving interdisciplinary teams.
		Collaborate with ACP CHWs in ACP attributed patient outreach for eligible asthmatic patients.		Develop a comprehensive ACP community resource guide.
		Continue to serve ACP attributed patients in their language and with the cultural sensitivity that characterizes the ACP network.		Integrate cultural competency and health literacy strategy to insure efficient communication and proper development of materials (for patient education and workforce training).
				Facilitate PCMH level 3 certification process through the work of ACP's PCMH level 3 content expert and vendors.
				Provide Care Management and Care Coordination to eligible ACP attributed patients.
Workforce Implications	Hire patient PNs to work in ACP network hospitals.	Train medical practice staff on project, asthma action plans, and referral process.	Educate staff of involved CBOs and public agencies on ACP PPS, project, and Stanford Model.	Hire and train project manager.
	Place ACP Community Health Workers (CHWs) in ACP hospitals' EDs.	Educate medical practice staff to make use of ACP resources for PCMH level 3 certification, Care Coordination and Care Management.		Hire and train ACP CHWs, Care Managers, Care Coordinators, PCMH level 3 content expert, and other PCMH support staff.
	Train PNs and CHWs on eligibility guidelines, referral process, and electronic patient tracker.			
Workforce Environment/ Constraints	Role of ACP CHWs spread throughout projects.	Increased use of medical assistants in private practices	Potential resistance of out of network CBOs and NYC public agencies to establish partnerships with ACP.	Limited number and availability of ACP Care Managers, Care Coordinators, PCMH level 3 content expert, and other PCMH support staff.
	Potential resistance of hospitals to hire PNs.	Limited resources.		Role of ACP CHWs spread throughout projects.
Occupational specific redeployment, training, and hiring	Hiring of PNs.	Train physician to implement evidence-based asthma protocol, develop comprehensive asthma action plans for their patients.	Offer training to CBOs and public agency staff on ACP PPS, project, and evidence-based asthma protocols.	Hire project manager, PCMH level 3 content experts, other PCMH support staff, Care Coordinators, Care Managers, and CHWs.
	Train CHWs and PNs on project, patient eligibility guidelines, referral process, and technology tools used for patient engagement.	Train Medical Assistants, or appropriate staff identified by PCP or practice lead, on project, referral process, and ACP community resource guide.		Project manager to complete online *Master Certificate in Applied Project Management-Healthcare* through Villanova University.
				Certify PCMH level 3 content manager expert.
				Project managers received NCQA HEDIS training.
				Train Care Coordinators, Care Managers, CHWs, and others on project protocols ACP community resource guide, Stanford Model, and Coleman transition of care models.

ACP Project Requirement Analysis: 4.b.i Tobacco Use Cessation

Project Manager: Katherine Morillo

Overall objective: To decrease the prevalence of cigarette smoking by adults 18 and older; increase use of tobacco cessation services including NYS Smokers' Quitline and nicotine replacement products.

	Hospitals	Medical Practices	CBOs	ACP PPS
Objectives	Reduce avoidable ED visits and hospitalizations of ACP attributed patients.	PCPs to achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models.	Support ACP attributed patients in tobacco use intervention programs and prevent visits to ED.	Promote tobacco use cessation among smokers, especially among low socio-economic status.
	Implement the US Public Health Service Guidelines for Treating Tobacco Use.	Promote tobacco use cessation services counseling, referrals to NY Quits, and nicotine replacement products.	Work with ACP to address needs, including social services, of eligible ACP attributed patients.	Increase Medicaid and other health plan coverage of tobacco dependency treatment counseling and medications.
		Equip medical practice staff to properly implement project.	Implement the US Public Health Service Guidelines for Treating Tobacco Use.	Implement the US Public Health Service Guidelines for Treating Tobacco Use.
		Implement the US Public Health Service Guidelines for Treating Tobacco Use.		
Strategies	Identify ACP attributed patients who are hospitalized or visit the ED due to tobacco related ailments through EHR information exchange platforms (RHIOs) and/or patient	Implement ACP's Tobacco Use Intervention program and provide total PCMH level 3 care to patients.	Establish referral process with ACP to meet the needs of eligible ACP attributed patients.	Develop tobacco use intervention program that promotes tobacco cessation, and promote adoption of tobacco-free outdoor policies.
	Implement system transformation projects' protocols to insure that ACP attributed patients who are hospitalized or visit the ED visit their PCP, and that Health Home at-risk patients, PPA and PPRs are identified, properly referred, and monitored.	Screen patients for tobacco use, promote cessation counseling among smokers, including people with disabilities, refer smokers through warm hand-offs to community-based services, NY Quits, and provide language appropriate, culturally sensitive educational materials.	Address ACP attributed patients' community needs by establishing partnerships with NYC public agencies.	Collaborate with health plans to create universal, consistent health insurance benefits for prescription and over-the counter cessation medications.
	Facilitate tobacco use intervention programs to ACP for patient referral and other efforts.	Collaborate with ACP to promote tobacco cessation through community-centered, lifestyle modification educational seminars and campaigns.	Assist ACP by identifying services and point of contact person for the development of a comprehensive ACP community resource guide.	Develop a comprehensive ACP community resource guide.
	Refer eligible patients to ACP care managers and care coordinators.	Use EHR to complete five As (ask, assess, advise, assist, and arrange) and use appropriate HEDIS coding metrics.	Collaborate with ACP to promote tobacco cessation through community-centered, lifestyle modification educational seminars and campaigns.	Integrate cultural competency and health literacy strategy to insure efficient communication and proper development of materials (for patient education and
		Continue to serve ACP attributed patients in their language and with the cultural sensitivity that characterizes the ACP network.		Facilitate PCMH level 3 certification process through the work of ACP's PCMH level 3 content expert and vendors.
		Refer eligible patients to ACP care managers and care coordinators.		Provide Care Management and Care Coordination to eligible ACP attributed patients, and facilitate referrals to NY Quits.
Workforce Implications	Hire patient PNs to work in ACP network hospitals.	Train medical practice staff on project, referral process, and HEDIS coding metrics.	Educate staff of involved CBOs and public agencies on ACP PPS and tobacco use intervention strategies.	Hire and train project manager.
	Place ACP Community Health Workers (CHWs) in ACP hospitals' EDs.	Educate medical practice staff to make use of ACP resources for PCMH level 3 certification, Care Coordination and Care Management.		Hire and train ACP CHWs, Care Managers, Care Coordinators, PCMH level 3 content expert, and other PCMH support staff.
	Train PNs and CHWs on eligibility guidelines, referral process, and technology tools used for patient engagement.			
Workforce Environment/ Constraints	Role of ACP CHWs spread throughout projects.	Increased use of medical assistants in private practices	Potential resistance of out of network CBOs and NYC public agencies to establish partnerships with ACP.	Limited number and availability of ACP Care Managers, Care Coordinators, PCMH level 3 content expert, other PCMH support staff, and provider engagement specialists.
	Potential resistance of hospitals to hire PNs.	Limited resources.		Role of ACP CHWs spread throughout projects.
Occupational specific redeployment, training, and hiring	Hiring of PNs.	Train physicians and appropriate staff to use EHR to complete five As, HEDIS coding metrics, and implement tobacco use intervention program, including warm hand-offs.	Offer training to CBOs and public agency staff on ACP PPS and project.	Hire project manager, PCMH level 3 content experts, other PCMH support staff, Care Coordinators, Care Managers, and CHWs.
	Train CHWs and PNs on project, patient eligibility guidelines, referral process, and technology tools used for patient engagement.			Project manager to complete online *Master Certificate in Applied Project Management-Healthcare* through Villanova University.
				Certify PCMH level 3 content manager expert.
				Project manager and other appropriate staff to be trained on tobacco use intervention programs.
				Train Care Coordinators, Care Managers, CHWs, and others on project protocols ACP community resource guide, and Coleman transition of care models.
				Project managers received NCQA HEDIS training.

ACP Project Requirement Analysis: 4.b.ii Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings

Project Manager: Katherine Morillo

Overall objective: To increase the numbers of New Yorkers who receive evidence based preventive care and management for chronic diseases (this project targets chronic diseases that are not included in Domain 3, such as cancer).

	Hospitals	Medical Practices	CBOs	ACP PPS
Objectives	Reduce avoidable ED visits and hospitalizations of ACP attributed patients.	PCPs to achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models.	Support ACP attributed patients by connecting them to community preventive resources and prevent visits to ED.	Increase the number of ACP attributed patients who receive evidence-based preventice care and management for chronic disease in both clinical and community settings.
		Equip medical practice staff to properly implement project.	Work with ACP to address needs, including social services, of eligible ACP attributed patients.	
Strategies	Identify ACP attributed patients who are hospitalized or visit the ED through EHR information exchange platforms (RHIOs) and/or patient navigators (PNs).	Implement ACP's Chronic Disease project and provide total PCMH level 3 care to patients with an emphasis on team-based care.	Establish referral process with ACP to meet the needs of eligible ACP attributed patients.	Develop chronic disease prevention evidence-based protocol.
	Implement system transformation projects' protocols to insure that ACP attributed patients who are hospitalized or visit the ED visit their PCP, and that Health Home at-risk patients, PPA and PPRs are identified, properly referred, and monitored.	Screen patients for chronic diseases, such as cancer, following evidence-based guidelines, send reminders for preventative care and follow-ups, and provide language appropriate, culturally sensitive educational material.	Address ACP attributed patients' community needs by establishing partnerships with NYC public agencies.	Develop a comprehensive ACP community resource guide with linkages to community preventive resources.
	Incorporate prevention agenda goals and objectives into hospital community service plans, and coordinate implementation with local NYC DOHMH and other community partners.	Collaborate with ACP to promote chronic disease prevention through community-centered, lifestyle modification educational seminars.	Collaborate with ACP to host/facilitate Stanford Model workshop sites, and community-centered, lifestyle modification educational seminars.	Integrate cultural competency and health literacy strategy to insure efficient communication and proper development of materials (for patient education and workforce training).
	Collaborate with ACP to incorporate prevention agenda.	Continue to serve ACP attributed patients in their language and with the cultural sensitivity that characterizes the ACP network.	Assist ACP by identifying services and point of contact person for the development of a comprehensive ACP community resource guide.	Facilitate PCMH level 3 certification process through the work of ACP's PCMH level 3 content expert and vendors.
		Offer recommended clinical preventive services, connect patients to community-based preventive service resources and ACP care managers/care coordinators.		Establish or enhance reimbursement and incentive models to increase delivery of high-quality chronic disease prevention and management services in collaboration with heatlh plans and other stakeholders.
				Provide feedback to clinicians around clinical benchmarks and incentivize quality improvement efforts.
				Provide Care Management and Care Coordination to eligible ACP attributed patients.
Workforce Implications	Hire patient PNs to work in ACP network hospitals.	Train medical practice staff on project, screening guidelines, referral process, and HEDIS coding metrics.	Educate staff of involved CBOs and public agencies on ACP PPS and chronic disease screenings.	Hire and train project manager.
	Place ACP Community Health Workers (CHWs) in ACP hospitals' EDs.	Educate medical practice staff to make use of ACP resources for PCMH level 3 certification, Care Coordination and Care Management.		Hire and train ACP CHWs, Care Managers, Care Coordinators, PCMH level 3 content expert, and other PCMH support staff.
	Train PNs and CHWs on eligibility guidelines, referral process, and electronic patient tracker.			
Workforce Environment/ Constraints	Role of ACP CHWs spread throughout projects.	Increased use of medical assistants in private practices.	Potential resistance of out of network CBOs and NYC public agencies to establish partnerships with ACP.	Limited number and availability of ACP Care Managers, Care Coordinators, PCMH level 3 content expert, and other PCMH support staff.
	Potential resistance of hospitals to hire PNs.	Limited resources.		Role of ACP CHWs spread throughout projects.
Occupational specific redeployment, training, and hiring	Hiring of PNs.	Train physicians and appropriate staff to implement Chronic Disease Prevention Project.	Offer training to CBOs and public agency staff on ACP PPS and project.	Hire project manager, PCMH level 3 content experts, other PCMH support staff, Care Coordinators, Care Managers, and CHWs.
	Train CHWs and PNs on project, patient eligibility guidelines, referral process, and technology tools used for patient engagement.			Project manager to complete online *Master Certificate in Applied Project Management-Healthcare* through Villanova University.
				Certify PCMH level 3 content manager expert.
				Project manager and other appropriate staff to receive population health training.
				Train Care Coordinators, Care Managers, CHWs, and others on project protocols ACP community resource guide, Stanford Model, and Coleman transition of care models.
				Project managers received NCQA HEDIS training.

ACP DSRIP Support Hires

As the only physician-led PPS in the State of New York, ACP faces unique workforce transformation challenges. Facilitating, supporting, and monitoring the labor force transformation required for proper implementation of DSRIP mandates is the core purpose of ACP. ACP's workforce as whole consists of new hires committed to this colossal task. All positions at ACP were created to provide support related to DSRIP. The Exhibit below documents ACP's workforce projections for DY1-DY5.

The "New Hire Position Title" column indicates titles of staff hired/to be hired by the PPS to provide support throughout the DSRIP program. The "Current Number" column indicates the total number of staff (by headcount) currently hired by the PPS for each corresponding tile.

The "Target Number" column indicates the total number of staff that the PPS plans to hire (by headcount) to provide support by the end of the DSRIP program.

The "Total New Hires" column indicates (by headcount) whether staff that are currently filling and/or are planned to fill the positions will be either new hire or redeployed/retrained staff.

New Hire Position Title	Current Number	Target Number	Total New Hires
Chief Executive Officer	1	1	1
Executive Assistant	1	1	1
Chief Operations Officer	1	1	1
VP of Operations	2	2	2
Administrative Staff	4	4	4
Project Managers	11	11	11
Other Project Support Staff	2	2	2
Chief Financial Officer	1	1	1
Director of Finance	1	1	1
Accountants and Analysts	2	6	6
Controller	1	1	1
Directors, Network & Provider Operations	1	2	2
Physician Engagement Specialists	4	12	12
PCHM Content Experts	1	2	2
Chief Technology Officer	1	1	1
Director of Data/Analytics	1	1	1
Data Analysts	4	4	4
Chief Information Officer	1	1	1
Support Staff	0	3	3
VP of Workforce	1	1	1
Director of Workforce	1	1	1
Director of CCHL	1	1	1
CCHL Support Staff	0	2	2
Manager of Community Health Workers (CHWs)	1	1	1
Supervisors of CHWs	4	5	5

CHWs	19	50	50
Community Engagement Specialists	0	4	4
Analyst	0	1	1
Director of Multicultural Diversity Programs and Development	1	1	1
Assistant	1	1	1
Chief Medical Officer	**1**	**1**	**1**
Care Managers (RNs)	2	6	6
Utilizations Managers (RNs)	0	6	6
Care Coordinator	0	7	7
VP of Legal Affairs	**1**	**1**	**1**
Legal Coordinator	1	1	1
Administrative Support	1	1	1
VP of Human Resources	1	1	1
Administrative Support	1	1	1
VP of Communications	1	1	1
Director of Integrated Outreach	1	1	1
Marketing Coordinator	1	1	1
Compliance Officer	1	1	1
Support Staff	0	2	2
Total DSRIP-Related Positions	**81**	**156**	**156**

Training Plan Overview

ACP PPS was founded in 2014 and officially incorporated in 2015 to participate in the DSRIP program. Unlike other PPSs, ACP is a physician-led network consisting predominantly of neighborhood medical practices and, as such, it faces unique challenges and opportunities. Supporting and monitoring the labor force transformation required for proper implementation of DSRIP mandates is the core purpose of ACP. In order to deliver this colossal task, ACP PPS's leadership structured the organization and its workforce to be the facilitators of this transformation for its network. The PPS leadership determined from the onset that training would constitute an organizing principle and a major function of the entire PPS.

Based on the training project requirements, ACP identified the following courses by department/staff line:

ACP Training Plan Overview			
Training	**Trainer/Entity/Vendor**	**Trainee**	**Objective**
DSRIP 101 Tutorial and Video (onboarding)	1199SEIU TEF	ACP staff and providers	Educate ACP staff, partners, providers, and staff on DSRIP transformation and project metrics.
DSRIP & ACP PPS Project Specific Protocols (on-site)	ACP Physician Engagement Specialists & Project Managers		
DSRIP & ACP PPS Project Specific Protocols (group training)			
Healthcare Effectiveness Data and Information Set (HEDIS)	National Committee for Quality Assurance (NCQA	ACP staff and providers	Train staff on HEDIS performance measures.
2014 Level 3 Patient Centered Medical Home (PCMH) Content Certified Expert		ACP PCMH support staff and others	Develop in-house content expert to facilitate PCP transformation to attain 2014 PCMH Level 3 Certification.
2014 PCMH Level 3 Support	CCACO, Insight Management, HQ Analytics, and Precision Quality.	ACP staff and providers	Service network PCPs with transformation specialist to help them become 2014 PCMH Level 3 Certified.
Data Analytics	General Assembly	ACP Data Analysts	Use descriptive statistical analysis to make informed, effective decisions on large data sets in order to better serve ACP's technology and population health needs.
Community Health Worker: Core Training and Ongoing Seminars	SIANI Consultants, LLC	ACP CHWs	Provide ACP CHWs with a comprehensive training to prepare them to carry out patient engagement, home visits, and other duties.

Master Certificate in Applied Project Management Healthcare	Villanova University	ACP Project Managers	Enhance project managers' overall productivity and performance.
Stanford Model: Chronic Disease Self-Mangement	Health People	Selected CHWs, care coordinators, and patients.	Prepare selected group to carry out workshops in the community to promote chronic disease self-management.
	Quality and Technical Assistance Center (QTAC)		
Health Insurance Portability and Accountability Act (HIPAA)	Healthicity	ACP staff and providers	Train ACP staff and network providers on protecting the privacy and security of patients' health information.
Code of Conduct and Compliance	ACP Compliance Department		Provide ACP staff and network providers with understanding of DSRIP specific compliance requirements and best practice.
Care Management/Care Coordination	Centene	Centene staff	Provide training to Care Managers/Care Coordinators and back office staff
Approach to lifestyle modification for children	Get Focused on Reading	ACP staff	Train ACP staff on innovative approach to engage children in exercise and reading.
Salient Medicaid Enterprise System Analyst Training Classes	Salient HHS	ACP Data Analysts, Project Managers, and others	Train appropriate staff on NYS Salient Medicaid Enterprise to access and manipulate data on NYS Medicaid claims, encounters, and related to examine Medicaid populations and utilization.
Care Navigator (onboarding)	MediSys Care Navigator Trainers	MediSys Primary Care Navigators and other staff	Prepare Navigators and other staff to help patients on their path toward health improvement by training them on pre-visit planning, Epic, MyChart, Medical Interpretation, Missing Member Services, ED Triage and 30-Day Care Transition projects.
Jamaica Hospital ED (onboarding)	MediSys Emergency Department Referral Navigator	MediSys ED Referral Navigators	
Flushing Hospital ED (onboarding)			
DSRIP Asthma Project	MediSys DSRIP Facilitators	MediSys Primary Care Navigators and other staff	
Physician Follow Up Scheduling	MediSys Patient Information Representative	MediSys Patient Information Representative and Nursing Manager	

Patient-Centered Medical Home Transformation

The NCQA PCMH model is a way of organizing primary care that emphasizes care coordination and communication to transform primary care into "what patients want it to be." ACP's objective is to provide the resources necessary for independent practices to achieve PCMH 2014 Level 3 certification, which intertwines with all of ACP's ten DSRIP projects in concert with effective patient care. This will also facilitate the technology and connectivity requirements as required by DSRIP. Below are the six standards and elements of PCMH:

PCMH 1: Patient Centered Access	• Schedule slots for same-day appointments to routine and urgent care. • Extend office hours during week. • Alternative type of clinical encounters (i.e., 24/7 telephone access, group appointments). • Electronic access (i.e., download health information, two-way e-communication). • Document QI for wait times (i.e., "third next available appointment").
PCMH 2: Team Based Care	• Continuity – written care plans and defined process for pediatric to adult care transition. • Patient education (on care coordination, evidence-based care, behavioral health, medical records, etc.). • Meet cultural and linguistic needs of patients. • Define team structure, roles and training. • Schedule patient care team meetings.
PCMH 3: Population Health Management	• Document patient information and clinical information as structured/searchable data. • Document health risks and information needs (i.e., immunizations/screenings, medical history, communication needs, risky behaviors). • Identify patients and send reminders on: preventative care, immunizations, chronic/acute services, medications (at least annually). • Use EHRs for point-of-care reminders.

PCMH 4: Care Management and Support	• Establish criteria for identifying patients for care management, including:
	  • Behavioral health conditions
	  • High cost/utilization
	  • Poorly controlled or complex conditions
	  • Social determinants of health
	  • Outside referrals
	• For identified patients, develop written care plans that include goals, potential barriers and self-management plan.
	• Review/reconcile medications; e-prescribe.

PCMH 5: Care Coordination and Care Transitions	• Track, flag and follow-up on lab and imaging results. • Formal/informal agreements with specialists – track and follow up on referrals; document patient co-management. • Integrate behavioral health within practice site. • Identify patients with unplanned admissions and ED visits; follow-up care after discharge.
PCMH 6: Performance Measurement and Quality Improvement	• Measure and act to improve clinical quality performance (i.e., immunizations, preventive care, chronic/acute care) and resource use (i.e., care coordination, utilization). • Identify and act to improve disparity in care/services for vulnerable population. • Obtain feedback on patient/family experience.

ACP will facilitate and assist in the 2014 PCMH level 3 certification process for 748 providers in 560 practices before December 31, 2017. ACP has identified the network providers that need PCMH transformation services and categorized them into four groups:

Paper to Electronic Health Record Transformation

ACP has had numerous discussions with physicians still utilizing paper medical records. Some physicians are open to covert to an Electronic Health Record (EHR), but there are some physicians who may not agree to conversion; these physicians are nearing retirement age. The timeline for conversion aligns with the overall timeline for PCMH.

For those who are open to converting, ACP has negotiated special pricing and added features for its two key EHR partners, MDLand and eClinicalworks. For MDLand, this includes a pre-defined process that works with the physician workflow, which was created specifically for DSRIP reporting and performance goals. Additionally, there are back-end processes that can easily adapt to Regional Health Information Organization (RHIO) connectivity, such as various consent tracking mechanisms, a centralized reporting data repository that can analyze across the board performance, PCMH pre-validation points and future-state processes such as easier tracking of screenings such as the PHQ2/9. For eClinicalworks, the processes are similar including RHIO connectivity, population health dashboards, and PCMH pre-validation points and dashboards. These options are also open to providers who are using an EHR platform outside of MDLand and eClinicalworks.

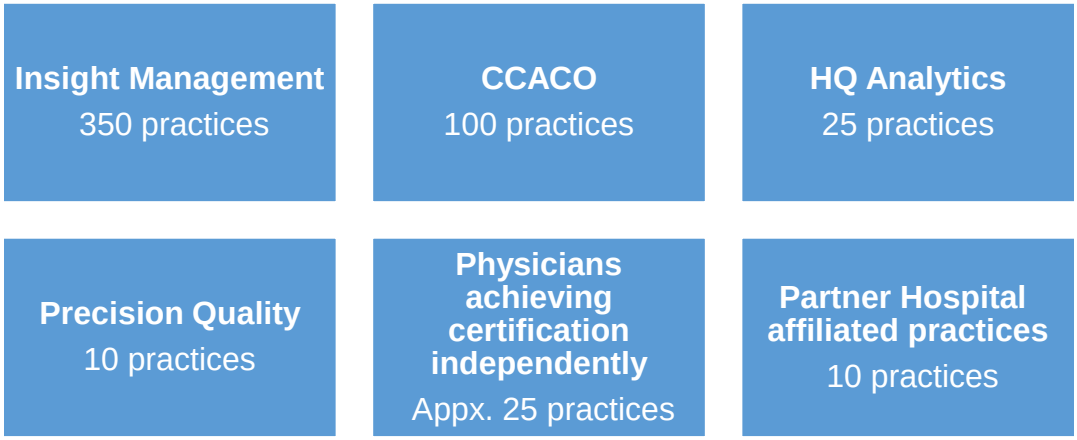
ACP is combining the efforts of transitioning paper-based medical records providers with PCMH. This allows for an extra incentive for physicians to transition into an EHR.

PCMH Transition Roadmap

ACP is helping its network of primary care physicians achieve PCMH certification to improve and transform their practices. While many of ACP's PCPs provide high quality, patient-centered care, formalizing the processes in the office has shown to improve accessibility, performance and quality. Appointment availability wait times have been reduced, preventive care has increased and quality care gap close rates are much higher. Some of these metrics are evident in the feedback from Managed Care Organizations (MCOs) provided to the IPAs within ACP, preventive care and quality scores have improved for PCMH Level 3 practices.

ACP has carefully selected vendors based on historical track record and the ability to form relationships with its community-based primary care physician network. These vendors have worked with the practices in the past, often being the same vendor who has helped them attain 2008 and 2011 Level 3 certifications. This granular level of familiarity is helpful as each vendor carefully understands practice capabilities, workflows, established processes and office culture. The vendors understand strengths and weaknesses and can provide the practice with tailored guidance in order to meet criteria. Some of our vendors also employ certified content experts who have worked with NCQA and fully understands requirements. ACP is leveraging this additional level of expertise and lending to physicians to assist with improvement of their practice.

The costs of acquiring PCMH certification is being covered by ACP, a benefit for primary care physician practices. These costs are fully covered if the practice selects a preferred ACP vendor, where costs have been contractually agreed, and are subsidized if a practice elects to use a vendor on their own. ACP believes that providing financial assistance to these primary care physician practices is appropriate to help satisfy DSRIP requirements. Many of the projects selected by ACP are very primary care-centric and ACP has to ensure that best practices are adopted within these community-based practices so that patient engagement and quality performance impact the overall DSRIP goal of reducing avoidable hospitalizations and emergency department use. ACP has already seen improved performance with practices who previously attained the 2008 and 2011 certifications and the expectations are the same not just for the practices with historical success with PCMH, but for our primary care practices globally.

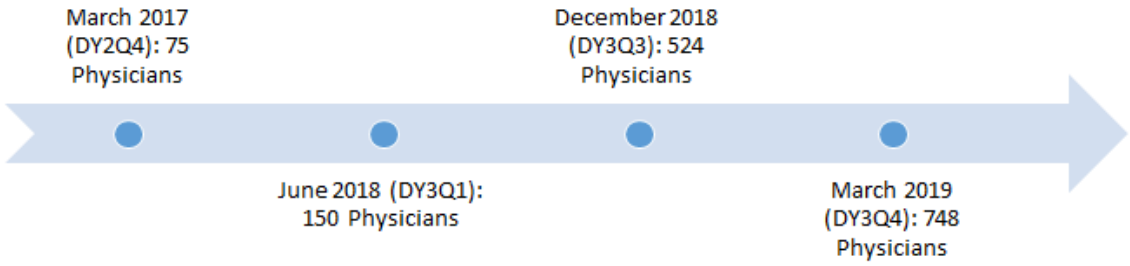


These 560 practices represent 748 physicians, or the number of physicians ACP has committed to in achieving PCMH level 3 certification.

Recruitment efforts to provide expertise and financial assistance to ACP's network of primary care practices are well underway. Because of the structure of ACP's approach, as well as the long-term relationships it has with its physicians, many physicians are very open to improving

their practices by working toward PCMH Level 3 certification. The insular nature of the IPAs and the relationship between its physicians makes it simpler to identify physician champions who have influence. ACP leverages these relationships to also help with its recruitment efforts. Lastly, the State Medicaid incentive of up to $8 PMPM for a practice with level 3 certification translates into significant sums for practices, some with as many as thousands of Medicaid patients. This incentive is heavily promoted in an effort to recruit physicians to become certified. All of these approaches are welcomed by PCPS and make the transition to PCMH widely accepted.

Overall, ACP's PCMH strategy has been widely accepted and many physicians are taking advantage of the subsidies. The benefits will be evident to ACP as well. Improved quality ratings, appropriate coding and documentation and diligent patient engagement will lead to outcomes that the DSRIP program expects.



PCMH Certification Process by Vendor

1. **Conduct gap analysis for each practice**
    a. Conduct onsite gap analysis between current operational, clinical, and EHR baseline and PCMH certification requirements using narrative and algorithmic reporting
    b. Analyze workflow and staff roles, EHR functionality, and reporting capabilities
    c. Present Gap Analysis in both quantitative (NCQA PCMH points achievable) and qualitative (a narrative analysis of clinical, operational and EHR strengths and weaknesses, proficiencies and deficiencies)

2. **Develop a customized work plan for each practice**

Work plan includes timelines, areas of concentration, remedial actions required, training schedules, goals; and outcome tracking mechanisms, benchmarks for measuring, and reporting to practice and ACP clinical condition selection.

3. **Hands-on, in-practice approach.**

Onsite, one-on-one training and transformation model; vendor does not rely on webinars or a practice staff member to execute transformation. Trainers are onsite an average of 30-50 hours for small practice transformations.

    a. Multi-lingual
    b. Workflow mapping and support for transformation
    c. Onsite training of professionals and staff
    d. Performance monitoring (remote electronically and onsite visits)
    e. Development of policies and procedures for sustainability

4. **Provide regular reporting to ACP.**

Monitors progress of practice and intervenes where necessary in order to stay on target.

    a. ACP Reporting: Weekly/monthly meeting with ACP as required using Vendor's Practice Tracking tool. ACP has online access to Vendor Practice Tracking tool
    b. Practice monitoring, implementation, and intervention:
        i. Onsite implementation of work plan
        ii. Operational evaluation and support;
        iii. Clinical condition selection;
        iv. Training of professionals and staff
        v. Implementation of standards and objectives
        vi. Performance monitoring (remote electronically and onsite visits)
        vii. Preparation, submission and revisions of applications
        viii. Manage pre-certification audits
        ix. Develop policies and procedures for sustainability
        x. Conduct chart reviews and using the record review workbook

5. **Workflow mapping and support.**

Using results of gap analysis, guides practice through necessary workflow changes and ensure appropriate documentation is captured.

The transformation team develops the work plan, sets deadlines, and organizes responsible practice staff assigned to specific tasks. Transformation goals are set for the practice, each department (i.e. administration, clinical support, providers) and individuals. Vendor monitors, implements and tracks all work flow modifications and documentation required.

6. Assists with NCQA application including any necessary revisions

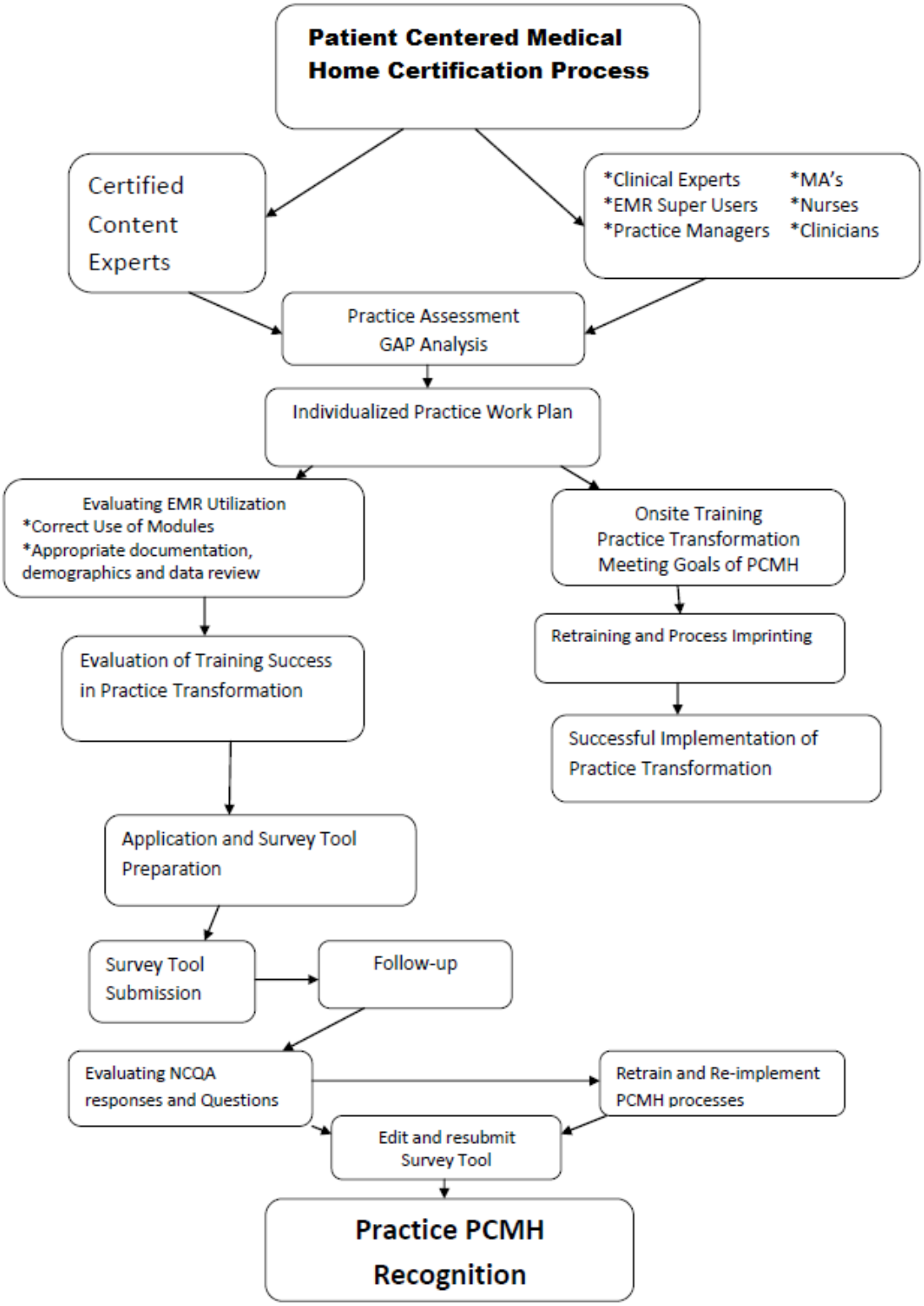
Vendor provides a complete turnkey program with onsite implementation and training for transformation, including preparation, submission, and revisions of application and survey tool for certification, tracking of the application and survey tool, resubmission if required and complete management of the NCQA process.

a. Developing policies and procedures
b. Prepare the NCQA PCMH application
c. Determine and develop the documentation and data required
d. prepare and submit application and NCQA's Interactive Survey Tool
e. Conducting chart reviews and using the record review workbook
f. Manage Pre-Certification Audits

PCMH vendor timeline sample:

What we do	Time Required
Gap Analysis	1 – 3 weeks (depending on practice size)
On-Site Practice Transformation*	30 - 120 days
Application preparation/submission	5-8 days (depending on new or renewal)
NCQA Evaluation/Scoring Feedback with Submission Updates	45 – 90 days
Pre-Certification Audit (if necessary)	4 – 6 days
Resubmission (if necessary)	30 – 60 days

Source: Insight Management, Gap Analysis Plan. September 2016.



Source: Insight Management, Gap Analysis Plan. September 2016.