Alliance will hire a CHW supervisor and 4 CHWs to partner with existing community based organizations to expand efforts to connect individuals to insurance and additional resources, and do capture data regarding CC among providers and HL needs of members.

Alliance will conduct community based listening sessions, and will review and assess provider based patient satisfaction surveys to obtain feedback regarding our efforts.

Alliance's CCHL taskforce will collaborate with our Workforce Committee to monitor the effectiveness of all CCHL training components conducted at our partner sites.

**Specific Objectives:**

Meet performance targets:

- 10% year over year Improvement in PAM scores demonstrated by Flourish data
- 10% year over year Decrease ER visits of uninsured demonstrated by DOH findings
- 10% year over year Increase preventive; primary care; and behavior health care access demonstrated by claims data
- 10% year over year Reduce hospital readmissions demonstrated by claims data
- Quarterly review of existing patient satisfaction surveys

**R13 The IA requires the PPS to assess the status of its network partners' involvement in VBP.**

**R14 The IA requires that the PPS establish a plan to further educate and support their partners move towards VBP arrangements.**

**Response:**

**Background:**

Initially PPSs were envisioned as contracting entities for network partners. The Alliance strategically aligned with IHANY, an ACO, to fulfil this contracting role. IHANY has been successful in executing one such contract with an MCO and is working on others. In addition there are other entities in the region that are creating MCO contracting products, and value based MSO services that align with our shared goal of migrating the community to value based care models.

**Current State:**

DOH has pushed back the due date on all VBP related requirements and the DSRIP program focus has shifted from an expectation of that the PPS would create VBP contracting through the MCOs, to one in which the PPS would educate, coordinate and facilitate value based contracting along many vectors.

The Alliance completed a review of Member involvement in VBP arrangements during the Fall of 2015, and has been a participant in conversations with medical groups, MCOs, and of course our members, as we have worked to understand and then evangelize the opportunities for value based contracting in the community.

**Analysis:**

Our sample size for the 2015 VBP survey is too small and too dated to be useful today, and our conversations provide only anecdotal evidence of the region's readiness to engage in value based contracting. Nonetheless, it is clear that our region has neither an MCO nor a care delivery organization that has yet made a firm commitment to migrating a significant portion of their business to value based models.

Our pivot away from a project focus to an Incentive focus will pull our network providers into a VBP oriented experience, focusing on reductions in fee-for-service claims, which translate into incentive funds to be shared among partners who have met their objectives. This strategy, combined with a new emphasis on driving MCOs and care providers toward value based care will provide additional incentive for the region to continue the traverse toward value based payment models.

**Desired Future State:**

A partner population educated about VBP and comfortable operating in a VBP environment.

**Actions:**

Alliance has re-allocated $2,000,000 to fund partner implementation of innovative initiatives through the balance of the measurement year ending June 30, 2017 (the "Fast-Start Incentive Program").

Alliance will develop and implement a Long-Term Incentive program focused on clusters encompassing the comprehensive set of outcome measure. Funds will be re-allocated to maximize the Incentive fund.
We will develop a thorough VBP survey and administer it to a sufficient sample size to objectively assess the status of Alliance's network partner involvement in VBP.

Alliance will develop a VBP curriculum, and deliver the VBP training to our Members, Board of Managers, community providers, and MCO staff. This VBP training and education will be coordinated where possible with adjacent PPSs, and will enlist the subject matter expertise of our MCO network partners, or MCO partners from other regions that have been more successful in migrating to the new payment models.

**Specific Objectives:**

Develop and administer a VBP needs assessment.

Develop a VBP curriculum.

Roll out training to Members.

Roll out training to Managers.

Roll out training to all partners.

Dedicate staff to VBP education, facilitation, coordination and evangelism.

**R15 The IA requires the PPS to develop an action plan to increase partner engagement, in particular for PCPs and Behavioral Health partners.**

**R16 The PPS must develop a detailed plan for engaging partners across all projects with specific focus on Primary Care, Mental Health, Substance Used Disorder providers as well as Community Based Organizations (CBOs). The Plan must outline a detailed timeline for meaningful engagement.**

**The Plan must also include a description of how the PPS will flow funds to partners so as to ensure success in DSRIP.**

**The PPS must also submit a detailed report on how the PPS will ensure successful project implementation efforts with special focus on projects identified by the IA as being at risk.**

**Response:**

**Background:**

Alliance's Fund Flow strategy initially was limited to a Project Fund focused on the implementation of projects and completion of DOH dictated requirements. Collaborative teams were formed by Alliance's partners, along naturally occurring patient service areas lines, (hubs). Alliance Payments to providers for this project implementation activity are performance based, focusing on meeting targets including partner and patient engagement. Financial awards to these Collaboratives were sized based on several criteria including the depth and breadth of Collaborative Participation to encourage partner engagement across all projects.

**Current State:**

We completed much of our project implementation contracting in the Fall of 2016. The Fund Flow detail of this MPA response (action plan), reflects the contracting completed after the MPA snapshot DY2Q2.

Our governance structure reflects the diversity of provider types including Committee representation by PCPs, BH providers, CBOs, and SUD providers.

**Analysis:**

Partner engagement in Alliance's Board structure is strong, consisting of our Member representatives, two independent practitioners, one of the region's largest private physician groups, and a representative of our PAC, as well as over 50 different partners who serve on one or more governance committees.

Reflecting the shift of DOH funding from reporting to performance, our focus is shifting as well. Our analytics team has identified a set of near-term opportunities through the balance of the

measurement year ending June 30, 2017, which forecasts our gap-to-goal outcome performance opportunities. With a provider led working group of clinicians, quality, and financial personnel, we have identified key measure clusters on which we will focus in the near term. The Incentive emphasizes the role of community based providers and physicians, and de-emphasize the role of hospitals.

There are approximately 519 primary care providers (PCPs) in our region that have attributed Medicaid beneficiaries. Over 92% of these providers are open to new Medicaid beneficiaries. Of these 519 PCPs, 254 also participate in overlapping PPSs. In addition, the network has 573 specialists and 257 hospital based specialists. Our five Member organizations include three large hospital systems (SPHP, Ellis, and SMHA) and two FQHCs (Whitney M. Young Jr. Health Center and Hometown Health Center), all of which employ both primary care and behavioral health providers.

**Desired Future State:**

An actively participating partner population across all projects, representative of a diverse set of provider types, with intentional engagement of primary care and behavioral health providers.

**Actions:**

Alliance will use Collaboratives and workgroups of diverse provider types to implement projects, while simultaneously expanding beyond project implementation (the Project Fund), to directly focus on outcome measures (the Incentive Fund). The primary objective of this pivot to incentive funding is to improve the health of our population as determined by performance improvement against a comprehensive set of outcome measures representing all our DSRIP projects. The premise of the Incentive Fund is that the most effective interventions emphasize the role of community based providers and physicians, and de-emphasize the role of hospitals.

We will allocate $2,000,000 for incentives to partners implementing a set of initiatives through the balance of the measurement year ending June 30, 2017. This “Fast Start” Incentive program will be closely monitored and adjusted to both maximize current performance, and inform the development of Alliance’s Long Term Incentive program.

Alliance will develop a Long-Term Incentive program around clusters that encompass the comprehensive set of outcome measures and will shift budgeted funds from Loss or Revenue to Incentives to maximize engagement.

We will focus our provider led incentive working group of clinicians, quality, and financial personnel on developing a program that maximizes partner engagement – especially in the areas of behavioral health and primary care, as these domains form the foundation of a healthy population.

**Specific Objectives:**

Hire a full-time Medical Director of Public Health to drive clinical alignment and partner engagement. This leader will have both behavioral health and primary care training, and will ideally have an MPH as well.

Create a new VP position focused exclusively on CBO engagement.

Create of a new director position focusing on PCP engagement.

Hire staff to specifically engage the practices and provide services, from one-on-one and team consulting, to hands-on activities.

Extend Project Fund contracts through DY3.

Implement Fast-Start Incentive program.

Implement Long-Term Incentive program.

**R17 The PPS is required to submit a report that describes the overall strategic organizational approach to DSRIP and how the PPS is currently resourcing and will resource going forward this approach.**

**Response:**

**Background:**

Our organizational structure was designed to implement 11 DSRIP projects. Partner led collaboratives were formed to complete all DOH dictated Milestones. The Project Fund Flow methodology linked partner payments to the completion of requirements, including partner and patient engagement commitments. Payments to Partners were adjusted based on bi-annual performance as determined by DOH. This aligns with the basic premise of DSRIP: project requirement completion will cause the 10% year-over-year performance improvement on DOH outcome measures, and the result will be a healthier population, reduced acute care utilization, and reduced overall cost (The Triple Aim).

**Current State:**

Alliance has demonstrated strong performance against DOH dictated organizational requirements (building the infrastructure for operating a PPS).

We completed much of our project implementation contracting in the Fall of 2016. The Fund Flow detail of this MPA response (action plan), reflects the contracting completed after the MPA snapshot DY2Q2.

Communication engagement activities have failed to achieve some objectives, and we have yet to facilitate the important shift of focus for our partners from project reporting to clinical performance.

**Analysis:**

The Alliance is a start-up PPS and therefore has not been able to take advantage of existing infrastructure, staff, or IT resources of a parent organization. This is good (we have agility and a true focus on serving our community) and bad (we had to start from scratch). In addition, our senior leadership for the initial ~ 30 months of DSRIP was shared with IHANY, a MSSP Accountable Care Organization that was created by two of our five Members (owners). While the shared staff and physical space provided some fiscal advantage during the launch of both companies, there were also unintended consequences that reduced the PPS team's ability to focus on DSRIP priorities. A key challenge, in retrospect, was a conflation of the strategic goals of the ACO and the PPS. While convergent, the strategic goals of these organizations are not identical, and with the same leadership, governed by separate Boards with some overlapping members, a single long-term strategy was developed to merge the work of the PPS into IHANY

– creating a contracting entity that would negotiate value based contracts with MCOs on behalf of PPS participants. Subsequently, DOH modified its' position and clarified that VBP contracting with PPS participants would be done through the MCOs, with PPS facilitation.

Reflecting the shift of DOH funding from reporting to performance, our focus is shifting as well. Our analytics team has identified a set of near-term opportunities through the balance of the measurement year ending June 30, 2017, which forecasts our gap-to-goal outcome performance opportunities. With a provider led working group of clinicians, quality, and financial personnel, we have identified key measure clusters on which we will focus in the near term, and will expand our performance focus in measurement year 3.

**Desired Future State:**

A healthier population, with more appropriate use of health care resources, as measured by meeting DOH identified performance goals.

An engaged partner community (providers, CBOs, hospitals, MCOs) that is focused on value based care delivery models.

An informed, educated, and empowered patient population.

**Actions:**

Alliance is making a Strategic investment in performance objectives. The Alliance has re-allocated $2,000,000 from operating funds and our strategic reserve to fund partners' implementation of innovative initiatives through the balance of the measurement year ending June 30, 2017 (the "Fast-Start Incentive Program") toward meeting performance gaps that had historically received insufficient attention. The incentive working group determined that the most effective interventions emphasized the role of community based providers and physicians, and de-emphasized the role of hospitals. The program will be closely monitored and adjusted to both maximize current performance, and inform to development of Alliance's Long-Term Incentive Program.

The Alliance is developing the Long-Term Incentive program focused on clusters encompassing the comprehensive set of outcome measures. Funds (DSRIP budget categories) will be re-allocated to maximize the Incentive fund, to fully emphasize the performance goals of the program. Our provider led working group of clinicians, community care organizations, quality leaders, and financial personnel will seek to increase partner engagement in the community through their vital role in the development of this Long-Term Incentive program.

Alliance has modified our leadership structure and allocation of funds to empower a focused, autonomous, agile company that will better engage with the community, implement the Incentive programs, and increase provider and patient understanding of value based care models, and how these new habits will improve health and the health care experience for all.

**Specific Objectives:**

Re-allocate Loss-of-Revenue budgeted funds to Incentives.

Implement Fast-Start Incentive Strategy.

Implement Long-Term Incentive Strategy.

Achieve 10% gap-to-goal performance improvement for key goals in measurement year 2

Appointment of a CEO dedicated 100% to DSRIP.

Hire a CTO to drive the critical IT infrastructure development.

Hire a full-time Medical Director to drive clinical alignment and partner engagement.

Create a new VP position focused exclusively on CBO engagement.

Create a new director position focusing on PCP engagement.

Create a new director position focusing on marketing and communication.

Add five community health workers, and four care managers.

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

Execute DY3 Long-Term Incentive Fund Contracts

**Alliance for Better Health Care, LLC #03**

| **Mid-Point Assessment Recommendation #1: 2.b.iii The IA recommends the PPS develop a training strategy to address the patient lack of knowledge regarding the shift to primary and preventive care away from the ED** | |
|---|---|
| ***PPS Defined Milestones/Tasks*** | ***Target Completion Date*** |
| MILESTONE 1: Add marketing and communications resources to develop and implement a multimedia campaign | DY3Q1 |
| MILESTONE 2: Hire CHWs and Care Coordinators | DY3Q1 |
| MILESTONE 3: Hire Medical Director to educate providers | DY3Q1 |
| MILESTONE 4: Work with Providers and Practices to promote changing their after hours phone messages to include information regarding alternatives to "dialing 911 and get to the ED" | DY3Q1 |
| **Mid-Point Assessment Recommendation #2: 2.b.iv The IA recommends the PPS develop a strategy to centralize the approach it is taking across the network to address care transitions and include behavioral health and psychosocial issues** | |
| ***PPS Defined Milestones/Tasks*** | ***Target Completion Date*** |
| MILESTONE 1: Develop incentive strategy | DY3Q1 |
| *Task 1 - Obtain Board approval* | DY3Q1 |
| *Task 2 - Develop communication plan* | DY3Q1 |
| *Task 3 - Create administrative guide for providers* | DY3Q1 |
| MILESTONE 2: Support our partners to implement evidence based best practice tools | DY3Q2 |
| *Task 1 - SBAR tool will be promoted by Alliance as the standard, best practice tool for use across the Alliance network of providers.* | DY3Q2 |
| *Task 2 - Gain consensus on additional tools to be implemented across the continuum* | DY3Q2 |
| *Task 3 - Provide est practice patient risk assessment tool during the inpatient stay to guide the discharge process.* | DY3Q2 |
| *Task 4 - Offer partners technical support to implement the selected tool(s) using Alliance Care management system* | DY3Q2 |
| MILESTONE 3: Coordinate collaboration between partner hospitals and community agencies | DY3Q1 |
| *Task 1 Hire CHWs and Care Coordinators* | DY3Q1 |

| | |
|---|---|
| *Task 2 Analytics to identify common patients* | DY3Q1 |
| MILESTONE 4 - Offer hospitals the opportunity for Alliance to augment their existing care management resources | DY3Q2 |
| *Task 1 - Alliance to provide analytics to partner hospitals* | DY3Q2 |
| MILESTONE 5 - Implement a Care Management system and secure messaging service | DY3Q1 |
| *Task 1 - Implement messaging system using Care Connects* | DY2Q4 |
| *Task 2 - Implement CrossChx Care Management system for use by Alliance Care managers and network partners as requested.* | DY3Q1 |
| **Mid-Point Assessment Recommendation #3: 2.b.iv The IA recommends the PPS educate their network partners about the available models of transitions of care** | |
| ***PPS Defined Milestones/Tasks*** | ***Target Completion Date*** |
| MILESTONE 1: Train Network partners on the multiple models of transitions of care | DY2Q4 |
| *Task 1 - Town Hall educational meeting with Dr. Amy Boutwell to train community providers* | DY2Q4 |
| *Task 2 - INTERACT Training to network partners care management staff* | DY2Q4 |
| *Task 3 - Educate network partners on models of transitions of care in Alliance project workgroup meetings* | DY2Q4 |
| MILESTONE 2: Participate in the NYS DOH MAX Series | DY2Q4 |
| *Task 1 - Alliance to participate in MAX series and identify network hospital to participate* | DY2Q4 |
| *Task 2 - Alliance to identify staff to be trained as MAX series trainers* | DY2Q4 |
| **Mid-Point Assessment Recommendation #4: 2.b.viii The IA recommends the PPS develop a strategy in conjunction with home health agencies to align the documentation in order to prevent miscommunication and missing information** | |
| ***PPS Defined Milestones/Tasks*** | ***Target Completion Date*** |
| MILESTONE 2: Conduct INTERACT Training | DY2Q4 |
| MILESTONE 3 - Conduct INTERACT Leadership Training | DY3Q1 |
| *Task 1 - schedule training* | DY3Q1 |
| MILESTONE 4: Provide patient education zone sheets to network partners | DY2Q4 |
| *Task 1 - Assist partners to incorporate zone sheets into their procedures for discharge planning.* | DY2Q4 |
| MILESTONE 5: Offer hospitals the opportunity for Alliance to augment their existing care management | DY3Q1 |
| *Task 1 - Alliance to provide analytics to partner hospitals* | DY3Q2 |
| MILESTONE 6: Implement a Care Management system and secure messaging service | DY3Q1 |
| *Task 1 - Implement messaging system using Care Connects* | DY3Q1 |
| *Task 2 - Implement CrossChx Care Management system for use by Alliance Care managers and network* | DY3Q1 |
| **Mid-Point Assessment Recommendation #5: 2.b.viii The IA recommends that the PPS workforce committee develop a strategy to recruit home health-aids** | |
| ***PPS Defined Milestones/Tasks*** | ***Target Completion Date*** |

| | |
|---|---|
| MILESTONE 1: Expand number of Community Health Workers. | DY3Q2 |
| **Mid-Point Assessment Recommendation #6: 3.d.ii. Strategy to recruit certified asthma educators** | |
| ***PPS Defined Milestones/Tasks*** | ***Target Completion Date*** |
| MILESTONE 1: Provide Asthma Educator training programs for licensed professionals for 2017 | DY3Q2 |
| MILESTONE 2: Provide Kettering AE-C Board Examination prep course for 2017 | DY3Q2 |
| **Mid-Point Assessment Recommendation #7: 3.d.ii. Develop a standard curriculum for asthma home-based educators** | |
| ***PPS Defined Milestones/Tasks*** | ***Target Completion Date*** |
| MILESTONE 1: Adopt Asthma Education for the Community Health Worker training curriculum | DY2Q4 |
| **Mid-Point Assessment Recommendation #8: 3.d.ii. Strategy to engage patient population in project** | |
| ***PPS Defined Milestones/Tasks*** | ***Target Completion Date*** |
| MILESTONE 1: Continue working with our collaborating partners and CBO's to develop methods to identify, extract and report engaged patients from the various EHR systems in place | DY2Q4 |
| **Mid-Point Assessment Recommendation #9: Action plan addressing CBO engagment and contracting** | |
| ***PPS Defined Milestones/Tasks*** | ***Target Completion Date*** |
| MILESTONE 1: Establish a CBO Executive Committee (CEC) | DY3Q1 |
| MILESTONE 2: Establish regionally based CBO Collaboratives (RSC). | DY3Q1 |
| MILESTONE 3: Execute DY3 Project Fund addendum | DY2Q4 |
| MILESTONE 4: Execute Incentive Fund addendum | DY3Q2 |
| MILESTONE 6: VP CBO Engagement in place | DY2Q4 |
| **Mid-Point Assessment Recommendation #10: Develop strategy to address how it will measure the effectiveness CCHL outreach** | |
| ***PPS Defined Milestones/Tasks*** | ***Target Completion Date*** |
| MILESTONE 1: Measure effectiveness of pilot organizational assessments (organizational competence, staff awareness, patient satisfaction survey) | DY3Q2 |
| *Task 1: Conduct organizational assessments at pilot (2 FQHC) site locations* | DY3Q1 |
| *Task 2: Review pilot site assessment(s) outcomes and analyze successes/gaps and use results to drive training plan* | DY3Q1 |
| *Task 3: Assist pilot sites in developing comprehensive training plan that address gaps* | DY3Q1 |
| *Task 4: Initiate pilot sites CCHL training plan* | DY3Q1 |
| *Task 5: Develop method to evaluate and modify training plan as needed* | DY3Q1 |
| *Task 6: Identify 2 additional sites for strategy roll out* | DY3Q1 |

| | |
|---|---|
| *Task 7: Replicate best practices from first wave of pilot sites to the 2 additional pilot sites for strategy roll out* | DY3Q2 |
| MILESTONE 2: Assess ability to measure impact of patient-centered outcomes by implementing a comprehensive CCHL training strategy | DY3Q2 |
| *Task 1: Develop plan that will outline timeframe of baseline member utilization data to be used in the measure and determines timeframe to begin reviewing data once training strategy is implemented* | DY3Q2 |
| *Task 2: Plan the research and Identify a framework, generate hypothesis, and determine study population and research design* | DY3Q2 |
| *Task 3: Begin to collect data to measure impact of CCHL training on identified population, and plan to conduct full study in 2018 and annually thereafter* | DY3Q2 |
| **Mid-Point Assessment Recommendation #11: Develop a strategy to better address the CCHL training needs of its partners** | |
| ***PPS Defined Milestones/Tasks*** | ***Target Completion Date*** |
| MILESTONE 1: Review of outcomes of cultural competency organizational assessments | DY2Q4 |
| *Task 1:Evaluate results of the assessments, identify training needs and develop training plans* | DY2Q4 |
| MILESTONE 2: Engage Community Health Workers (CHWs) in hot spot locations | DY3Q1 |
| Task 1: Hire and train CHW supervisor and 4 CHWs and deploy to hot spots areas. | DY3Q2 |
| MILESTONE 3: Collaborate with Workforce to distribute and analyze cultural competency/health literacy training needs survey to contracted partners that were not part of the pilot program | DY3Q1 |
| *Task 1: Develop survey questions* | DY3Q1 |
| *Task 2: Distribute survey through Survey Monkey* | DY3Q1 |
| *Task 3: Analyze survey results (CCHL taskforce to assist)* | DY3Q1 |
| *Task 6: Collaborate with Workforce to develop a plan that outlines ongoing CCHL training* | DY3Q1 |
| **Mid-Point Assessment Recommendation #12: The IA recommends that the PPS develop metrics to assess its most effective strategies to engage Medicaid members and the uninsured.** | |
| ***PPS Defined Milestones/Tasks*** | ***Target Completion Date*** |
| MILESTONE 1: Achieve 10% year over year improvement in PAM scores demonstrated by Flourish data | DY2Q4 |
| MILESTONE 2: Achieve 10% year over year decrease ER visits of uninsured demonstrated by DOH findings | DY2Q4 |
| MILESTONE 3: Achieve 10% year over year increase preventive; primary care; and behavior health care access | DY2Q4 |
| MILESTONE 4: Achieve 10% year over year reduction in hospital readmissions demonstrated by claims data | DY2Q4 |
| **Mid-Point Assessment Recommendation #13: The IA requires the PPS to assess the status of its network partner's involvement in VBP** | |
| ***PPS Defined Milestones/Tasks*** | ***Target Completion Date*** |
| MILESTONE 1: Develop a Value Based Payments Needs Assessment ("VNA") | DY3Q2 |
| MILESTONE 1: Administer Value Based Payments Needs Assessment ("VNA") | DY3Q2 |

| Mid-Point Assessment Recommendation #14: The IA requires that the PPS establish a plan to further educate and support their partners move towards VBP arrangements | |
|---|---|
| ***PPS Defined Milestones/Tasks*** | ***Target Completion Date*** |
| MILESTONE 1: Develop VBP educational curriculum | DY2Q4 |
| MILESTONE 2: Conduct VBP educational sessions with all Member organizations | DY3Q2 |
| MILESTONE 3: Conduct VBP educational sessions with all Manager organizations | DY3Q2 |
| MILESTONE 4: Roll out Incentive strategy to partners | DY3Q2 |
| MILESTONE 6: Develop VBP primer and release on-line to all partners | DY3Q2 |
| **Mid-Point Assessment Recommendation #15: Develop partner engagment action plan** | |
| ***PPS Defined Milestones/Tasks*** | ***Target Completion Date*** |
| MILESTONE 1: Hire CMO | DY2Q4 |
| MILESTONE 2: Create VP Community Engagment position | DY2Q4 |
| MILESTONE 3: Create Director PCP Engagement position | DY2Q4 |
| **Mid-Point Assessment Recommendation #16:** | |
| ***PPS Defined Milestones/Tasks*** | ***Target Completion Date*** |
| MILESTONE 1: Extend Project Fund addendums through DY3 | DY2Q4 |
| MILESTONE 3: Develop and implement Incentive program | DY3Q2 |
| **Mid-Point Assessment Recommendation #17: Overall strategic organizational approach** | |
| ***PPS Defined Milestones/Tasks*** | ***Target Completion Date*** |
| MILESTONE 1: Project Fund methodology for DY3-4 approved by Board | DY2Q4 |
| MILESTONE 2: Short Term Incentive methodology approved by Board | DY2Q4 |
| MILESTONE 3: Long Term Incentive methodology approved by Board | DY3Q1 |
| MILESTONE 4: Put new leadership resources in place | DY2Q4 |
| *Task 1: CEO* | DY2Q4 |
| *Task 3: CMO* | DY2Q4 |
| *Task 4: CIO* | DY2Q4 |
| *Task 5: VP PMO* | DY2Q4 |

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

| | | Partner Engagement | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Partner Category** | | ***2.a.i.*** | ***2.b.iii.*** | ***2.b.iv.*** | ***2.b.viii*** | ***2.d.i.*** | ***3.a.i.*** | ***3.a.iv.*** | ***3.d.ii.*** | ***3.g.i.*** | ***4.a.iii.*** | ***4.b.i.*** | |
| Practitioner - Primary Care | | | | 480 | | | 190 | 455 | | | | | |
| Practitioner - Non-Primary Care | | | | 299 | | | | 267 | | | | | |
| Hospital - Inpatient/ED | | | | 6 | 6 | | | 6 | | | | | |
| Hospital - Ambulatory | | | | | | | | | | | | | |
| Clinic | | | | | | | | | | | | | |
| Mental Health | | | | | | | 24 | 67 | | | | | |
| Substance Abuse | | | | | | | | 17 | | | | | |
| Case Management | | | | | | | | | | | | | |
| Health Home | | | | | | | | | | | | | |
| Community Based Organization (Tier 1) | | | 2 | 2 | | 7 | 1 | 1 | 3 | | 6 | 1 | |
| Nursing Home | | | | | | | | | | | | | |
| Pharmacy | | | | | | | | | | | | | |
| Hospice | | | | | | | | | | | | | |
| Home Care | | | | | 5 | | | | | | | | |
| Community Based Organization (Tier 2) | | | 2 | 2 | 3 | 2 | 1 | 1 | | 1 | 2 | 1 | |
| Community Based Organization (Tier 3) | | | 6 | 5 | 1 | 4 | 9 | 3 | | 5 | 5 | 1 | |
| Other (PAM Provider) | | | | | | 300 | | | | | | | |

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

| Alliance for Better Health Care PPS # 03 | | Funds Flow (all funds) | | | |
|---|---|---|---|---|---|
| **Partner Category** | | ***MAPP Funds Flow through DY2, Q3*** | ***Projected Funds Flow through DY2*** | ***% of Earned Dollars Planned for Distribution DY3*** | ***% of Earned Dollars Planned for Distribution DY4 DY5*** |
| Practitioner - Primary Care | | $ 2,596,288 | $ 880,918 | 15% | 15% |
| Practitioner - Non-Primary Care | | $ - | $ - | | |
| Hospital - Inpatient/ED | | $ 4,414,795 | $ 2,755,498 | 10% | 10% |
| Hospital - Ambulatory | | $ 1,734,120 | $ - | 5% | 5% |
| Clinic | | $ 4,545,269 | $ 1,119,265 | 14% | 14% |
| Mental Health | | $ 930,153 | $ 595,998 | 3% | 3% |
| Substance Abuse | | $ 1,401,923 | $ 531,760 | 3% | 3% |
| Case Management | | $ - | $ - | 3% | 3% |
| Health Home | | $ 450,000 | $ - | 1% | 1% |
| Community Based Organization (Tier 1) | | $ 380,309 | $ 188,135 | 8% | 8% |
| Nursing Home | | $ - | $ - | | |
| Pharmacy | | $ - | $ 16,128 | | |
| Hospice | | $ 78,502 | $ 14,251 | | |
| Home Care | | $ 1,977,141 | $ 1,887,779 | 14% | 14% |
| Community Based Organization (Tier 2) | | $ 276,438 | $ 361,508 | 8% | 8% |
| Community Based Organization (Tier 3) | | $ 690,768 | $ 396,868 | 8% | 8% |
| | | $ - | $ - | | |
| PMO | | $ 3,865,891 | | 8% | 8% |
| **Total** | | $ 23,341,597 | $ 8,748,108 | | |