WORKFORCE GAP ANALYSIS

DEPARTMENT OF WORKFORCE,
COMMUNITY, AND GOVERNMENT RELATIONS

PREPARED IN COLLABORATION WITH

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Gap Analysis 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) conducted a detailed gap analysis between the current state of the workforce and the projected target state to identify gaps in the labor force of the overall PPS, as well as needs and opportunities for retraining and redeployment.

In accordance with its Workforce Implementation Plan, ACP completed this analysis 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;
- A detailed Gap Analysis including Findings and Plan of Action to close gaps including steps, elements and target due dates; and
- An assessment and 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.

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

The gap analysis report 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 Gap Analysis

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.

Measuring the Gap Between Current and Target Workforce State

Once the estimates based on the current workforce capacity and the target workforce were finalized, ACP, with the assistance of CHWS as its workforce subject matter expert, proceeded to identify the potential gaps between those two estimates, understanding how the potential difference between them inform training, redeployment, and hiring needs of the ten ACP PPS projects. The current workforce survey, unfortunately, did not achieve a 100% response rate and thus can only be used as a guide. Similarly, the future state assessment was too broad to identify needs within specific facility types, especially private practitioner offices, and thus could also be used a guide.

That being said, several findings were identified that should be used as a starting point for understanding ACP training and hiring needs. First, registered nurses are not being used in private medical practices. The vast majority of practices use medical assistants for a combination of clerical, billing, and clinical activities. Additionally, physicians in many practices, especially smaller ones, provide both the operational functions (business, billing, human resources, IT, etc.) as well as clinical functions. Ultimately, for both medical assistants and physicians, ACP training and other assistance must account for multiple roles of these professionals in an already overworked environment.

The gap analysis also took into account current workforce issues. Continued shortages of primary care and mental health providers, especially for vulnerable populations such as those on Medicaid, need to be considered as the focus on increased access to care. At times, considering new models of care to ensure access, such as telehealth, or different models of educating providers, such as Project Echo, must be contemplated to ensure ultimate success of the projects. In order to provide additional staffing support to its network, ACP will hire community health workers, care coordinators, and care managers.

Finally, ACP projects must take into account different type of service provision to account for shortages of providers. Substitutions of nurse practitioners or physician assistants for primary care physicians or

social workers or self-help groups for behavioral health practitioners can address persistent shortages but still ensure the delivery of desired project outcomes.

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 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 Project Workforce State Analysis

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.

Understanding Project Strategies and Workforce Implications

The first step in the process is to understand how the strategies for each of the ten projects impact the workforce. ACP project staff, along with ACP management and CHWS 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 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.

Target State

The final step in the process was to identify the workforce approaches that will be used to meet the specific project strategies, tempering it with current workforce environmental constraints needs, which includes training, redeployment, or hiring of new staff to accomplish individual project objectives. 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. This constitutes the basis for developing the workforce transition roadmap.

Overview Gaps Identified & Target Dates by Providers for 2.a.i Integrated Delivery Systems

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	Target Due Date	Medical Practices	Target Due	CBOs	Target Due Date	ACP PPS	Target Due Date
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.	
Roadmap: Strategic Steps	Identify ACP attributed patients who are hospitalized or visit the ED through EHR information exchange platforms (RHIOs) and/or patient navigators (PNs).	DY2Q4	Identify person who will monitor PCMH certification progress and make use of ACP PCMH content expert and vendors.	DY1Q1	Establish referral process with ACP to meet the needs of eligible ACP attributed patients.	DY1Q4 On-going	Carry out a community needs assessment, workforce survey, IT needs and requirement assessment, clinical workflow survey, and financial sustainability survey.	DY2Q4
	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.	DY2Q4	Refer eligible patients to ACP's supporting staff for team-based care: Care Managers, Care Coordinators, and Community Health Workers.	DY1Q4	Address ACP attributed patients' community needs by establishing partnerships with NYC public agencies.	On-going	Utilize partnering HHs, ACOs, and IPAs population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.	DY3Q1
	Collaborate with Medicaid Managed Care Organizations (MCOs) regarding data sharing to help with patient identification process.	DY2Q3	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.	DY3Q2	Assist ACP by identifying services and point of contact person for the development of a comprehensive ACP community resource guide.	DY3Q2	Facilitate contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements	DY3Q1
	Insure that appropriate communication occurs regarding VBP initiatives that target hospitals.	DY2Q3	Continue to serve ACP attributed patients in their language and with the cultural sensitivity that characterizes the ACP network.	DY1Q1-On-going			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.	DY3Q1
			Insure that appropriate communication occurs regarding VBP initiatives that target medical practices.	OnGoing			Facilitate PCMH level 3 certification process through the work of ACP's PCMH level 3 content expert and vendors.	DY3Q4 On-going
							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.	DY2Q1 On-going
							Develop a comprehensive ACP community resource guide.	DY3Q2
							Provide appropriate technological tools to ACP staff to deploy strategic initiatives (i.e. tablets, hardware, and software).	DY2Q1 On-going
Gap Analysis/Implications	Hire patient navigators (PNs) to work in ACP network hospitals.	DY2Q4	Train medical practice staff on EHR systems, and ACP care management/coordination patient eligibility guidelines and referral process.	On-going	Educate staff of involved CBOs and public agencies on ACP PPS and integrated delivery systems project.	On-going	Hire project manager.	DY1Q2
	Place ACP Community Health Workers (CHWs) in ACP hospitals' EDs.	DY2Q4	Educate medical practice staff to make use of ACP resources for PCMH level 3 certification, Care Coordination and Care Management.	DY3Q2			Hire and train Value-Based/Medical Economics Analyst, Data Scientists, IDS Specialist/IT Coordinators, ACP CHWs, Care Managers, and Care Coordinators.	DY2Q4 On-going
	Train PNs and CHWs on eligibility guidelines, referral process, electronic patient tracker, RHIOs and HIE.	DY2Q1	Educate medical practice staff on ACP resources to facilitate VBP transition.	DY3Q1 On-going			Hire and train ACP PCMH level 3 content experts and other PCMH support staff.	DY1Q4
							Develop ACP core team for VBP to address network preparedness.	DY2Q3
Roadmap: Environmental 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.	
Target State: Occupational specifics (redeployment, training, and hiring)	Hire CHWs and PNs.	DY2Q4	Educate medical practice staff on ACP resources for PCMH level 3 certification.	On-going	Offer training to CBOs and public agency staff on ACP PPS and integrated delivery systems project.	On-going	Hire ACP project manager, PCMH level 3 content experts, Care Coordinators, Care Managers, and CHWs.	DY2Q4
	Train CHWs and PNs on project, patient eligibility guidelines, referral process, and technology tools used for patient tracking and engagement.	DY2Q4	Train medical practice staff on project, patient eligibility guidelines, and referral process.	On-going			Certify PCMH level 3 content manager experts and PCMH support staff.	DY2Q1 On-going
							Analysts to complete *Data Analytics* training at the General Assembly Campus in New York City.	DY2Q2
							Train Care Coordinators, Care Managers, and CHWs on IDS.	On-going

Overview Gaps Identified & Target Dates by Providers for 2.a.i Integrated Delivery Systems

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	Target Due Date	Medical Practices	Target Due Date	CBOs	Target Due Date	ACP PPS	Target Due Date
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.					
Roadmap: Strategic Steps	Identify ACP attributed patients who are hospitalized or visit the ED through EHR information exchange platforms (RHIOs) and/or patient navigators (PNs).	DY2Q4	Implement ACP's proper project procedures and protocols to provide total PCMH level 3 care.	DY2Q1	Establish referral process with ACP to meet the needs of eligible ACP attributed patients and establish ongoing communication.	DY1Q1 On-going	Through partnership and guidance of health homes develop evidence-based procedures and protocols to engage eligible ACP attributed patients and reduce these events.	DY3Q2
	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.	DY2Q4	Provide eligible at-risk patients comprehensive care plan, and refer eligible at-risk patients to ACP's Care Managers and Care Coordinators.	DY2Q1	Address ACP attributed patients' community needs by establishing partnerships with NYC public agencies.	On-going	Carry out a community needs assessment, workforce survey, IT needs and requirement assesment, clinical workflow survey, and financial sustainability survey.	DY2Q4
	Collaborate with Medicaid Managed Care Organizations (MCOs) regarding data sharing to help with patient identification process.	DY2Q3	PCP, or lead provider, to develop a practice culture that supports patient selt-management.	DY3Q4	Assist ACP by identifying services and point of contact person for the developmenf of a comprehensive ACP community resource guide.	DY3Q2	Develop a comprehensive ACP community resource guide.	DY3Q2
			Assist in identifying leaders and participants for ACP Stanford Model self-management workshops.	DY2Q3			Integrate cultural competency and health literacy strategy to insure efficient communication and proper development of materials (for patient education and workforce training).	DY2Q4 On-going
			Insure that coordination of stakeholders (i.e. health homes) is timely and accurate.	DY3Q2			Provide ACP medical practices with access to ACP staff: Care Managers, Care Coordinators, and CHWs.	DY2Q1 On-going
			Continue to serve ACP attributed patients in their language and with the cultural sensitivity that characterizes the ACP network.	On-going			Facilitate PCMH level 3 certification process through the work of ACP's PCMH level 3 content expert and vendors.	Dy3Q4 On-going
Gap Analysis/Implications	Hire patient navigators (PNs) to work in ACP network hospitals.	DY2Q4	Train medical practice staff on project, patient eligibility guidelines, and referral process.	On-going	Educate staff of involved CBOs and public agencies on ACP PPS and project.	On-going	Hire and train project manager.	DY1Q4
	Place ACP Community Health Workers (CHWs) in ACP hospitals' EDs.	DY2Q4	Educate medical practice staff to make use of ACP resources for PCMH level 3 certification, Care Coordination and Care Management.	DY3Q2	Place selected CHWs in CBOs in higher needs communities.	DY1Q3	Hire and train ACP CHWs, Care Managers, and Care Coordinators.	DY1Q4
	Train PNs and CHWs on eligibility guidelines, referral process, and technology tools used for patient engagement.	DY2Q1					Hire and train ACP PCMH level 3 content experts and other PCMH support staff.	
Roadmap: Environmental 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.							
Target State: Occupational specifics (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.	
							Train Care Coordinators, Care Managers, CHWs, and others on project protocols ACP community resource guide, Stanford Model, and Coleman transition of care models.	

Overview Gaps Identified & Target Dates by Providers for 2.b.iv Care Coordination & Transitional Care Programs

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	Target Due Date	Medical Practices	Target Due Date	CBOs	Target Due Date	ACP PPS	Target Due Date
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.	
Roadmap: Strategic Steps	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.	DY2Q4	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.	DY3Q2	Establish referral process with ACP to meet the needs of eligible patients.	DY1Q4	Develop project protocol, guidelines, and care transition protocol.	DY2Q3
	Collaborate with Medicaid Managed Care Organizations (MCOs) regarding data sharing to help with patient identification process and to develop transition of care protocols.	DY2Q3	Continue to serve ACP attributed patients in their language and with the cultural sensitivity that characterizes the ACP network.	On-going	Assist ACP by identifying services and point of contact person for the development of a comprehensive ACP community resource guide.	DY3Q2	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.	DY3Q2
	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.	DY3Q2	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.	DY2Q2	Provide services to ACP referred patients in their language when possible and with cultural competency.	DY1Q1 On-going	Develop infrastructure and connectivity necessary to facility secured communication among all stakeholders, i.e. hospital, Health Homes, PNs, CHWs, and PCPs.	DY3Q2
	Collaborate with ACP in emphasizing the value of having a PCP.	DY1Q2 On-going	Collaborate with ACP in improving provider to provider communications.	On-going	Collaborate with ACP in identifying community-based resources for patients post-hospitalization.	DY3Q2	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.	DY2Q2 On-going
	Engage with ACP, Health Homes, and MCOs to develop transition of care protocols that insure they are followed properly.	DY2Q2					Develop a comprehensive ACP community resource guide.	DY3Q2
	Work with ACP to make available community-based support and resources for patients post-hospitalization.	On-going					Provide appropriate technological tools to ACP staff to deploy strategic initiatives (i.e. tablets, hardware, and software).	DY2Q1 On-going
	Notify ACP, PCP, and Health Home care manager if applicable, about patients' admission and transmit discharge information for the patient to PCP.	DY2Q1					Integrate ACP CCHL strategy to insure efficient communication and patient engagement, and promote self-management.	DY2Q4
Gap Analysis/Implications	Hire patient navigators (PNs) to work in ACP network hospitals.	DY2Q2	Train medical practice staff on EHR systems, ACP care management/coordination patient eligibility guidelines and referral process, and care transition project.	On-going	Educate staff of involved CBOs and public agencies on ACP PPS and project.	On-going	Hire project manager.	DY1Q2
	Place ACP Community Health Workers (CHWs) in ACP hospitals' EDs.	DY2Q4	Educate medical practice staff to make use of ACP resources for PCMH level 3 certification, Care Coordination and Care Management.	DY2Q2			Hire and train Data Scientists, IDS Specialist/IT Coordinators, ACP CHWs, Care Managers, and Care Coordinators.	DY2Q4On-going
	Train PNs and CHWs on guidelines, referral process, electronic patient tracker, RHIOs, HIE, patient consultation, and provider education.	DY2Q1					Hire and train ACP PCMH level 3 content experts and other PCMH support staff.	DY1Q4
Roadmap: Environmental 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.	
Target State: Occupational specifics (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.	DY2Q4
	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.	DY2Q1 On-going
							Train CHWs, care coordinators, care managers, and other appropriate staff on project, guidelines, patient consultation, provider education, technology tools, CCHL, and metrics.	DY2Q4 On-going

Overview Gaps Identified & Target Dates by Providers for 2.b.iii ED care triage for at-risk populations

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	Target Due Date	Medical Practices	Target Due Date	CBOs	Target Due Date	ACP PPS	Target Due Date
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.	
Roadmap: Strategic Steps	Collaborate with ACP in establishing linkages to PCPs with emphasis on those who are PCMH level 3 certified.	DY2Q4	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.	DY2Q3	Establish referral process with ACP to meet the needs of eligible patients.	DY1Q4 On-going	Develop project protocol, guidelines, and scheduling process for PCP appointments.	DY2Q3
	Connect frequent ED users with the PCMH providers available to them.	DY2Q4	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.	DY3Q2	Assist ACP by identifying services and point of contact person for the development of a comprehensive ACP community resource guide.	DY3Q2	Establish linkages between EDs and PCPs, especially those that are PCMH level 3 certified, and insure effective provider to provider communication.	DY2Q3
	Notify ACP, PCP, and Health Home care manager if applicable, about patients' ED visit and transmit triage information for the patient to PCP.	DY2Q4	Continue to serve ACP attributed patients in their language and with the cultural sensitivity that characterizes the ACP network.	DY1Q1 On-going	Provide services to ACP referred patients in their language when possible and with cultural competency.	DY1Q4 On-going	Facilitate the process to connect frequent ED users with the PCMH providers available to them.	DY2Q3
	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.	DY2Q4	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.	DY2Q2			Develop infrastructure and connectivity necessary to facility secured communication among all stakeholders, i.e. ED, Health Homes, PNs, CHWs, and PCPs.	DY3Q2
	Integrate ACP cultural competency and health literacy strategy to insure efficient communication and patient engagement, and promote self-management.	DY2Q2	Collaborate with ACP in improving provider to provider communications.	On-going			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.	DY2Q2
	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.	DY3Q2					Develop a comprehensive ACP community resource guide.	DY3Q2
	Collaborate with ACP in emphasizing the value of having a PCP.	On-going					Provide appropriate technological tools to ACP staff to deploy strategic initiatives (i.e. tablets, hardware, and software).	DY2Q4
							Integrate ACP CCHL strategy to insure efficient communication and patient engagement, and promote self-management.	DY2Q2
Gap Analysis/Implications	Hire patient navigators (PNs) to work in ACP network hospitals.	DY2Q4	Train medical practice staff on EHR systems, ACP care management/coordination patient eligibility guidelines and referral process, and ED triage project.	On-going	Educate staff of involved CBOs and public agencies on ACP PPS and project.	On-going	Hire project manager.	DY1Q2
	Place ACP Community Health Workers (CHWs) in ACP hospitals' EDs.	DY2Q4	Educate medical practice staff to make use of ACP resources for PCMH level 3 certification, Care Coordination and Care Management.	DY3Q2			Hire and train Data Scientists, IDS Specialist/IT Coordinators, ACP CHWs, Care Managers, and Care Coordinators.	DY2Q4On-going
	Train PNs and CHWs on guidelines, referral process, electronic patient tracker, RHIOs, HIE, patient consultation, and provider education.	DY2Q1					Hire and train ACP PCMH level 3 content experts and other PCMH support staff.	DY1Q4
Roadmap: Environmental 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.	
Target State: Occupational specifics (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.	DY2Q4
	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.	DY2Q1 On-going
							Train CHWs, care coordinators, care managers, and other appropriate staff on project, guidelines, patient consultation, provider education, technology tools, CCHL, and metrics.	DY2Q4 On-going

Overview Gaps Identified & Target Dates by Providers for 3.a.i Integration Primary Care & Behavioral Health

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	Target Due Date	Medical Practices	Target Due Date	CBOs	Target Due Date	ACP PPS	Target Due Date
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.	
Roadmap: Strategic Steps	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).	DY3Q2	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).	DY3Q2	Address ACP attributed patients' community needs by establishing partnerships with NYC public agencies.	DY2Q2 On-going	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.	DY2Q4
	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.	DY2Q4	Coordinate with ACP's behavioral health partners and in-network hospitals to allow for warm handoffs to effectively and efficiently coordinate care.	DY3Q2	Increase linkages between health care and CBOs for behavioral health patients	DY3Q3	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.	DY3Q2
	Coordinate with ACP's behavioral health partners and PCPs to allow for warm handoffs to effectively and efficiently coordinate care.	DY3Q2	Continue to serve ACP attributed patients in their language and with the cultural sensitivity that characterizes the ACP network.	On-going	Increase identification and use of alcohol and substance use peer support groups	DY3Q2	Contract and designate consulting psychiatrists for implementation of the IMPACT model's collaborative care process (model 3).	DY3Q3
	Collaborate with mental health clinics at hospitals for the implementation of models 1 and 2.	DY2Q4	Implement ACP's proper project procedures and protocols to provide total PCMH level 3 care.	DY3Q2	Assist ACP by identifying services and point of contact person for the development of a comprehensive ACP community resource guide.	DY3Q2	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.	DY3Q3
							Collaborate with the State and City OMH in developing a comprehensive evidence-based SBIRT training for our PCPs and team.	DY3Q2
							Assist behavioral health partners in attaining and implementing PC services.	DY3Q2 On-going
							Develop relationships with alcohol and substance use support groups to provide community-based resources to help patients with ongoing needs.	DY3Q2
							Develop a comprehensive ACP community resource guide.	DY3Q2
							Establish roving interdisciplinary teams.	DY3Q3
							Integrate cultural competency and health literacy strategy to insure efficient communication and proper development of materials (for patient education and workforce training).	DY3Q2
							Facilitate PCMH level 3 certification process through the work of ACP's PCMH level 3 content expert and vendors.	On-going
Gap Analysis/Implications	Hire patient PNs and Behavioral Health (BH) Managers to work in ACP network hospitals.	DY2Q4	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.	DY3Q2	Increase the number of peer support groups support behavioral health patients and substance use disorder.	DY3Q2 On-going	Hire and train project manager.	DY1Q2
	Place ACP Community Health Workers (CHWs) in ACP hospitals' EDs.	DY2Q4	Train medical staff for IMPACT model implementation.	DY3Q2 On-going	Educate staff of involved CBOs and public agencies on ACP PPS, and project protocols.	DY3Q2 On-going	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.	DY1Q2 On-going
	Train PNs, BH Managers, and CHWs on eligibility guidelines, referral process, and technology tools used for patient engagement.	DY2Q1	Educate medical practice staff to make use of ACP resources for PCMH level 3 certification, Care Coordination and Care Management.	DY3Q2 On-going			Hire and train ACP CHWs, Care Managers, Care Coordinators, PCMH level 3 content experts, and other PCMH support staff.	DY2Q2 On-going
Roadmap: Environmental 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.							
Target State: Occupational specifics (redeployment, training, and hiring)	Hiring of PNs.	DY2Q2	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.	DY3Q2 Ongoing	Offer training to CBOs and public agency staff on ACP PPS, project, and referral process.	DY2Q2 On -going	Hire project manager, PCMH level 3 content experts, PCMH support staff, Care Coordinators, Care Managers, and CHWs.	DY2Q4
	Train CHWs and PNs on project, patient eligibility guidelines, referral process, and technology tools used for patient engagement.	DY2Q3 On going					Certify PCMH level 3 content manager experts.	DY2Q2
							Project manager to complete online *Master Certificate in Applied Project Management-Healthcare* through Villanova University.	DY2Q2
							Project managers received NCQA HEDIS training.	DY2Q2
							Train Care Coordinators, Care Managers, CHWs, and others on project protocols ACP community resource guide, Stanford Model, and Coleman transition of care models.	DY3Q2

Overview Gaps Identified & Target Dates by Providers for 3.b.i Cardiovascular Disease Management

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	Target Due Date	Medical Practices	Target Due Date	CBOs	Target Due Date	ACP PPS	Target Due Date
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.					
Roadmap: Strategic Steps	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).	DY3Q2	Implement ACP's project protocol and provide total PCMH level 3 care.	DY3Q2	Establish referral process with ACP to meet the needs of eligible ACP attributed patients.	DY3Q2	Carry out a community needs assessment and cardiovascular disease prevalence 'hotspot' analysis,	DY1Q2 On-going
	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.	DY2Q4	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.	DY2Q4 On-going	Address ACP attributed patients' community needs by establishing partnerships with NYC public agencies, and out of network CBOs.	On-going	Engage cardiovascular disease specialists and PCPs, identify and track cardiovascular disease patients with emphasis on "hotspots."	On-going
			Assist in identifying leaders and participants for ACP Stanford Model self-management workshops.	DY2Q3	Collaborate with ACP to host/facilitate Stanford Model workshop sites.	DY2Q4 On-going	Develop proper procedures and protocols to engage eligible ACP attributed patients and reduce avoidable ED visits and hospitalizations.	DY2Q4
			Refer eligible cardiovascular disease patients to ACP's Care Managers and Care Coordinators.	DY2Q2 On-going	Assist ACP by identifying services and point of contact person for the development of a comprehensive ACP community resource guide.	DY3Q2	Develop a comprehensive ACP community resource guide.	DY3Q2
			Collaborate with ACP CHWs in ACP attributed patient outreach for eligible cardiovascular disease patients.	DY2Q2 On-going			Establish roving interdisciplinary teams.	DY3Q2
			Implement Million Hearts campaign strategies.	On -going			Integrate cultural competency and health literacy strategy to insure efficient communication and proper development of materials (for patient education and workforce training).	DY3Q2
			Establish 'blood pressure stations' in each practice for patients to measure their blood pressure free of charge and without an appointment.	On-going			Facilitate PCMH level 3 certification process through the work of ACP's PCMH level 3 content expert and vendors.	DY2Q1 On-going
			Continue to serve ACP attributed patients in their language and with the cultural sensitivity that characterizes the ACP network.	On-going			Provide Care Management and Care Coordination to eligible ACP attributed patients.	DY2Q1 On-going
Gap Analysis/Implications	Hire patient PNs to work in ACP network hospitals.	DY2Q4	Train medical practice staff on project, cardiovascular disease care plans, Million Hearts campaign, blood pressure station, and referral process.	On-going	Educate staff of involved CBOs and public agencies on ACP PPS, project, and Stanford Model.	DY3Q3	Hire and train project manager.	DY1Q2
	Place ACP Community Health Workers (CHWs) in ACP hospitals' EDs.	DY2Q4	Collaborate with ACP CHWs in ACP attributed patient outreach for eligible cardiovascular disease patients.	On-going			Hire and train ACP CHWs, Care Managers, Care Coordinators, PCMH level 3 content expert, and other PCMH support staff.	DY2Q4 On-going
	Train PNs and CHWs on eligibility guidelines, referral process, and electronic patient tracker.	DY2Q1	Educate medical practice staff to make use of ACP resources for PCMH level 3 certification, Care Coordination and Care Management.	On-going				
Roadmap: Environmental 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.	
Target State: Occupational specifics (redeployment, training, and hiring)	Hiring of PNs.	DY2Q2	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.	On-going	Offer training to CBOs and public agency staff on ACP PPS and project.	On-going	Hire project manager, PCMH level 3 content experts, other PCMH support staff, Care Coordinators, Care Managers, and CHWs.	DY2Q4
	Train CHWs and PNs on project, patient eligibility guidelines, referral process, and technology tools used for patient engagement.	DY2Q3					Project manager to complete online *Master Certificate in Applied Project Management-Healthcare* through Villanova University.	DY2Q2
							Certify PCMH level 3 content manager expert.	DY2Q2
							Project managers received NCQA HEDIS training.	DY2Q2
							Train Care Coordinators, Care Managers, CHWs, and others on project protocols ACP community resource guide, Stanford Model, and Coleman transition of care models.	DY3Q2

Overview Gaps Identified & Target Dates by Providers for 3.c.i Diabetes Disease Management

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	Target Due Date	Medical Practices	Target Due Date	CBOs	Target Due Date	ACP PPS	Target Due Date
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.					
Roadmap: Strategic Steps	Identify ACP attributed patients who are hospitalized or visit the ED through EHR information exchange platforms (RHIOs) and/or patient navigators (PNs).	DY3Q2	Implement ACP's project protocol and provide total PCMH level 3 care.	DY3Q2	Establish referral process with ACP to meet the needs of eligible ACP attributed patients.	DY3Q2	Carry out a community needs assessment and diabetes prevalence 'hotspot' analysis.	DY1Q1
	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.	DY2Q4	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.	DY3Q3	Address ACP attributed patients' community needs by establishing partnerships with NYC public agencies, and out of network CBOs.	On-going	Engage diabetes specialists and PCPs, identify and track diabetic patients with emphasis on "hotspots."	DY2Q4
			Assist in identifying leaders and participants for ACP Stanford Model self-management workshops.	DY2Q3	Collaborate with ACP to host/facilitate Stanford Model workshop sites.	DY2Q3, On-going	Develop proper procedures and protocols to engage eligible ACP attributed patients and reduce avoidable ED visits and hospitalizations.	DY2Q3
			Refer eligible diabetic patients to ACP's Care Managers and Care Coordinators.	On-going	Assist ACP by identifying services and point of contact person for the development of a comprehensive ACP community resource guide.	DY3Q2	Develop a comprehensive ACP community resource guide.	DY3Q2
			Collaborate with ACP CHWs in ACP attributed patient outreach for eligible diabetic patients.	DY2Q4			Establish roving interdisciplinary teams.	DY3Q2
			Continue to serve ACP attributed patients in their language and with the cultural sensitivity that characterizes the ACP network.	On-going			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.	On-going
							Provide Care Management and Care Coordination to eligible ACP attributed patients.	On-going
Gap Analysis/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.	DY2Q4 On-going
	Train PNs and CHWs on eligibility guidelines, referral process, and electronic patient tracker.							
Roadmap: Environmental 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.	
Target State: Occupational specifics (redeployment, training, and hiring)	Hiring of PNs.	DY2Q1	Train Medical Assistants, or appropriate staff identified by PCP or practice lead, on project, referral process, and ACP community resource guide	On going	Offer training to CBOs and public agency staff on ACP PPS and project protocol.	DY2Q3 On going	Hire project manager, PCMH level 3 content experts, other PCMH support staff, Care Coordinators, Care Managers, and CHWs.	DY1Q2
	Train CHWs and PNs on project, patient eligibility guidelines, referral process, and technology tools used for patient engagement.	DY2Q3 On going					Project manager to complete online *Master Certificate in Applied Project Management-Healthcare* through Villanova University.	DY2Q2
							Certify PCMH level 3 content manager expert.	DY2Q2
							Project managers received NCQA HEDIS training.	DY2Q2
							Train Care Coordinators, Care Managers, CHWs, and others on project protocols ACP community resource guide, Stanford Model, and Coleman transition of care models.	DY2Q3 On going

Overview Gaps Identified & Target Dates by Providers for 3.d.iii Asthma

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	Target Due Date	Medical Practices	Target Due Date	CBOs	Target Due Date	ACP PPS	Target Due Date
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.					
Roadmap: Strategic Steps	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).	DY3Q2	Implement ACP's project protocol and provide total PCMH level 3 care.	DY3Q2	Establish referral process with ACP to meet the needs of eligible ACP attributed patients.	DY3Q2	Carry out a community needs assessment and asthma prevalence 'hotspot' analysis.	DY1Q1
	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.	DY2Q4	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.	DY3Q3	Address ACP attributed patients' community needs by establishing partnerships with NYC public agencies, and out of network CBOs.	On-going	Engage asthma specialists and PCPs, identify and track asthmatic patients with emphasis on "hotspots."	DY2Q4
			Assist in identifying leaders and participants for ACP Stanford Model self-management workshops.	DY2Q3	Collaborate with ACP to host/facilitate Stanford Model workshop sites.	DY2Q3, On-going	Develop proper procedures and protocols to engage eligible ACP attributed patients and reduce avoidable ED visits and hospitalizations.	DY2Q3
			Refer eligible asthmatic patients to ACP's Care Managers and Care Coordinators.	On-going	Assist ACP by identifying services and point of contact person for the development of a comprehensive ACP community resource guide.	DY3Q2	Establish roving interdisciplinary teams.	DY3Q2
			Collaborate with ACP CHWs in ACP attributed patient outreach for eligible asthmatic patients.	DY2Q4			Develop a comprehensive ACP community resource guide.	DY3Q2
			Continue to serve ACP attributed patients in their language and with the cultural sensitivity that characterizes the ACP network.	On-going			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.	On-going
							Provide Care Management and Care Coordination to eligible ACP attributed patients.	On-going
Gap Analysis/Implicationss	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.	DY2Q4 On-going
	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.							
Roadmap: Environmental 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.	DY1Q2
Target State: Occupational specifics (redeployment, training, and hiring)	Hiring of PNs.	DY2Q1	Train physician to implement evidence-based asthma protocol, develop comprehensive asthma action plans for their patients.	On-going	Offer training to CBOs and public agency staff on ACP PPS, project, and evidence-based asthma protocols.	DY2Q3 On going	Hire project manager, PCMH level 3 content experts, other PCMH support staff, Care Coordinators, Care Managers, and CHWs.	DY2Q2
	Train CHWs and PNs on project, patient eligibility guidelines, referral process, and technology tools used for patient engagement.	DY2Q3 On going	Train Medical Assistants, or appropriate staff identified by PCP or practice lead, on project, referral process, and ACP community resource guide.	On-going			Project manager to complete online *Master Certificate in Applied Project Management-Healthcare* through Villanova University.	DY2Q2
							Certify PCMH level 3 content manager expert.	DY2Q2
							Project managers received NCQA HEDIS training.	DY2Q2
							Train Care Coordinators, Care Managers, CHWs, and others on project protocols ACP community resource guide, Stanford Model, and Coleman transition of care models.	DY2Q3 On-going

<u>Overview Gaps Identified & Target Dates by Providers for 4.b.i Tobacco Use Cessation</u>

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	Target Due Date	Medical Practices	Target Due Date	CBOs	Target Due Date	ACP PPS	Target Due Date
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.					
Roadmap: Strategic Steps	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 navigators (PNs).	DY3Q2	Implement ACP's Tobacco Use Intervention program and provide total PCMH level 3 care to patients.	DY3Q3	Establish referral process with ACP to meet the needs of eligible ACP attributed patients.	DY3Q2	Develop tobacco use intervention program that promotes tobacco cessation, and promote adoption of tobacco-free outdoor policies.	DY2Q4
	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.	DY2Q2	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.	DY1Q2	Address ACP attributed patients' community needs by establishing partnerships with NYC public agencies.	On going	Collaborate with health plans to create universal, consistent health insurance benefits for prescription and over-the counter cessation medications.	DY2Q2
	Facilitate tobacco use intervention programs to ACP for patient referral and other efforts.	DY1Q4	Collaborate with ACP to promote tobacco cessation through community-centered, lifestyle modification educational seminars and campaigns.	DY2Q4	Assist ACP by identifying services and point of contact person for the development of a comprehensive ACP community resource guide.	DY3Q2	Develop a comprehensive ACP community resource guide.	DY3Q2
	Refer eligible patients to ACP care managers and care coordinators.	DY1Q4	Use EHR to complete five As (ask, assess, advise, assist, and arrange) and use appropriate HEDIS coding metrics.	DY3Q2	Collaborate with ACP to promote tobacco cessation through community-centered, lifestyle modification educational seminars and campaigns.	On going	Integrate cultural competency and health literacy strategy to insure efficient communication and proper development of materials (for patient education and workforce training).	DY2Q2
			Continue to serve ACP attributed patients in their language and with the cultural sensitivity that characterizes the ACP network.	OnGoing			Facilitate PCMH level 3 certification process through the work of ACP's PCMH level 3 content expert and vendors.	On going
			Refer eligible patients to ACP care managers and care coordinators.	DY2Q4			Provide Care Management and Care Coordination to eligible ACP attributed patients, and facilitate referrals to NY Quits.	On going
Gap Analysis/Implications	Hire patient PNs to work in ACP network hospitals.	DY2Q1	Train medical practice staff on project, referral process, and HEDIS coding metrics.	DY2Q1	Educate staff of involved CBOs and public agencies on ACP PPS and tobacco use intervention strategies.	On going	Hire and train project manager.	DY1Q2
	Place ACP Community Health Workers (CHWs) in ACP hospitals' EDs.	DY3Q1	Educate medical practice staff to make use of ACP resources for PCMH level 3 certification, Care Coordination and Care Management.	On going			Hire and train ACP CHWs, Care Managers, Care Coordinators, PCMH level 3 content expert, and other PCMH support staff.	On going
	Train PNs and CHWs on eligibility guidelines, referral process, and technology tools used for patient engagement.	DY2Q1						
Roadmap: Environmental 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.	
Target State: Occupational specifics (redeployment, training, and hiring)	Hiring of PNs.	DY2Q1	Train physicians and appropriate staff to use EHR to complete five As, HEDIS coding metrics, and implement tobacco use intervention program,	DY1Q2	Offer training to CBOs and public agency staff on ACP PPS and project.	On going	Hire project manager, PCMH level 3 content experts, other PCMH support staff, Care Coordinators, Care Managers, and CHWs.	On going
	Train CHWs and PNs on project, patient eligibility guidelines, referral process, and technology tools used for patient engagement.	DY2Q3 On going					Project manager to complete online *Master Certificate in Applied Project Management-Healthcare* through Villanova University.	
							Certify PCMH level 3 content manager expert.	On going
							Project manager and other appropriate staff to be trained on tobacco use intervention programs.	DY2Q2
							Train Care Coordinators, Care Managers, CHWs, and others on project protocols ACP community resource guide, and Coleman transition of care models.	DY2Q4
							Project managers received NCQA HEDIS training.	DY2Q2

Overview Gaps Identified & Target Dates by Providers for 4.b.ii Access to High Quality Chronic Disease Preventive Care in Clinical and Community Settings

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	Target Due Date	Medical Practices	Target Due Date	CBOs	Target Due Date	ACP PPS	Target Due Date
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 preventive 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.			
Roadmap: Strategic Steps	Identify ACP attributed patients who are hospitalized or visit the ED through EHR information exchange platforms (RHIOs) and/or patient navigators (PNs).	DY3Q2	Implement ACP's Chronic Disease project and provide total PCMH level 3 care to patients with an emphasis on team-based care.	On going	Establish referral process with ACP to meet the needs of eligible ACP attributed patients.	DY3Q2	Develop chronic disease prevention evidence-based protocol.	DY2Q3
	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.	DY2Q2	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.	On going	Address ACP attributed patients' community needs by establishing partnerships with NYC public agencies.	DY3Q2	Develop a comprehensive ACP community resource guide with linkages to community preventive resources.	DY3Q2
	Incorporate prevention agenda goals and objectives into hospital community service plans, and coordinate implementation with local NYC DOHMH and other community partners.	DY3Q2	Collaborate with ACP to promote chronic disease prevention through community-centered, lifestyle modification educational seminars.	On going	Collaborate with ACP to host/facilitate Stanford Model workshop sites, and community-centered, lifestyle modification educational seminars.	DY2Q4	Integrate cultural competency and health literacy strategy to insure efficient communication and proper development of materials (for patient education and workforce training).	DY2Q2
	Collaborate with ACP to incorporate prevention agenda.	On going	Continue to serve ACP attributed patients in their language and with the cultural sensitivity that characterizes the ACP network.	On going	Assist ACP by identifying services and point of contact person for the development of a comprehensive ACP community resource guide.	DY3Q2	Facilitate PCMH level 3 certification process through the work of ACP's PCMH level 3 content expert and vendors.	On going
			Offer recommended clinical preventive services, connect patients to community-based preventive service resources and ACP care managers/care coordinators.	DY3Q2			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.	DY3Q3
							Provide feedback to clinicians around clinical benchmarks and incentivize quality improvement efforts.	DY3Q3
							Provide Care Management and Care Coordination to eligible ACP attributed patients.	On-going
Gap Analysis/Implications	Hire patient PNs to work in ACP network hospitals.	DY2Q1	Train medical practice staff on project, screening guidelines, referral process, and HEDIS coding metrics.	On-going	Educate staff of involved CBOs and public agencies on ACP PPS and chronic disease screenings.	On Going	Hire and train project manager.	DY1Q2
	Place ACP Community Health Workers (CHWs) in ACP hospitals' EDs.	DY2Q4	Educate medical practice staff to make use of ACP resources for PCMH level 3 certification, Care Coordination and Care Management.	On Going			Hire and train ACP CHWs, Care Managers, Care Coordinators, PCMH level 3 content expert, and other PCMH support staff.	On Going
	Train PNs and CHWs on eligibility guidelines, referral process, and electronic patient tracker.	DY2Q1						
Roadmap: Environmental 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.	
Target State: Occupational specifics (redeployment, training, and hiring)	Hiring of PNs.	DY2Q1	Train physicians and appropriate staff to implement Chronic Disease Prevention Project.	On Going	Offer training to CBOs and public agency staff on ACP PPS and project.	On Going	Hire project manager, PCMH level 3 content experts, other PCMH support staff, Care Coordinators, Care Managers, and CHWs.	DY1Q2
	Train CHWs and PNs on project, patient eligibility guidelines, referral process, and technology tools used for patient engagement.	DY2Q2					Project manager to complete online *Master Certificate in Applied Project Management-Healthcare* through Villanova University.	DY2Q2
							Certify PCMH level 3 content manager expert.	DY2Q2
							Project manager and other appropriate staff to receive population health training.	DY2Q2
							Train Care Coordinators, Care Managers, CHWs, and others on project protocols ACP community resource guide, Stanford Model, and Coleman transition of care models.	Ongoing
							Project managers received NCQA HEDIS training.	DY2Q2

Findings and Plan of Action

The ACP Gap Analysis process established gaps in two general areas:

- Staffing
- Workforce Development and Training

The outcome of this process is fully documented in the detailed "ACP Project Requirements Analysis charts" (see pages 7-16 of this report). The analysis was conducted on a project-by-project basis in order to assure accuracy.

Staffing Gaps: ACP PPS

- ACP estimates a need for a total of 156 new positions within the PPS structure. To date, a total of 81 staff lines have been filled with approximately 75 remaining to complete the PPS staffing pattern. For a complete listing of each ACP position see pages 18-20 of this report.
  By DY3Q4 ACP PPS will be fully staffed, closing all staffing gaps.

- **Emerging Titles: Care Management/Coordination and Community Health Workers**
  DSRIP and more specifically, PCMH implementation, requires a staffing pattern that is beyond the financial means of most small, community based medical practices. The staffing pattern requires a cadre of Care Managers, Care Coordinators, and Community Health Workers. In order to close these gaps ACP will assemble a team of 50 CHWs. The CHWs are directly supervised by a Managerial team that includes: 1 Manager of CHWs, 1 CHW Program Supervisor and 4 CHW Field Supervisors.
  By DY2Q4 the CHW team will be hired.
  The PPS will hire approximately 19 Care Coordinators, Care Managers and Utilization Managers to support the implementation of the projects.
  By DY3Q4 the Care Management/Coordination team will be hired.

- The overall success of the PPS is closely linked to the ability to collect, store and analyze data. In order to close this gap the PPS will establish the following team that includes the following titles: Chief Information Officer, Chief Technology Officer, Director of Data/Analytics and 5 Data Analysts.
  By DY2Q4 the Data and Analytics team will be hired.

- **By DY1Q2 a PCMH Project Manager and a PCMH Content Expert will be hired.**

- ACP will establish a Physician/Provider Engagement unit to assure that medical practices in the ACP network are properly informed and trained for DSRIP performance. A total of 11 Physician/Provider Engagement Specialists will be hired and deployed throughout ACP's target area.
  By the end of DY3Q4, 11 Physician/Provider Engagement Specialists will be hired.

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 and organizing principle of ACP. ACP's workforce as whole consists of new hires committed to this 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 title.

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. The final column, "Timeline for Completion" represents the DSRIP timeline for completion of the hiring process.

Chart Illustrating ACP DSRIP Support Hires

New Hire Position Title	Current Number	Target Number	Total New Hires	Timeline for completion
Chief Executive Officer	1	1	1	DY1Q1
Executive Assistant	1	1	1	DY1Q1
Chief Operations Officer	1	1	1	DY2Q2
VP of Operations	2	2	2	DY1Q1
Administrative Staff	4	4	4	DY1Q1
Project Managers	11	11	11	DY1Q2
Other Project Support Staff	2	2	2	DY1Q3
Chief Financial Officer	1	1	1	DY1Q2
Director of Finance	1	1	1	DY2Q1
Accountants and Analysts	2	6	6	DY1Q2
Controller	1	1	1	DY2Q3
Directors, Network & Provider Operations	1	2	2	DY2Q2
Physician Engagement Specialists	4	12	12	DY1Q1
PCHM Content Experts	1	2	2	DY1Q1
Chief Technology Officer	1	1	1	DY1Q1
Director of Data/Analytics	1	1	1	DY2Q1
Data Analysts	4	4	4	DY1Q1
Chief Information Officer	1	1	1	DY2Q2
Support Staff	0	3	3	DY2Q2
VP of Workforce	1	1	1	DY2Q1
Director of Workforce	1	1	1	DY1Q1
Director of CCHL	1	1	1	DY1Q1
CCHL Support Staff	0	2	2	DY2Q3
Manager of Community Health Workers (CHWs)	1	1	1	DY1Q1
Supervisors of CHWs	4	5	5	DY2Q3
CHWs	19	50	50	DY2Q4
Community Engagement Specialists	0	4	4	DY2Q4
Analyst	0	1	1	DY2Q4
Director of Multicultural Diversity Programs and Development	1	1	1	DY2Q1
Assistant	1	1	1	DY2Q1
Chief Medical Officer	1	1	1	DY1Q1
Care Managers (RNs)	2	6	6	DY2Q1
Utilizations Managers (RNs)	0	6	6	DY2Q4
Care Coordinators	0	7	7	DY2Q4
VP of Legal Affairs	1	1	1	DY1Q1
Legal Coordinator	1	1	1	DY1Q1
Administrative Support	1	1	1	DY1Q1
VP of Human Resources	1	1	1	DY2Q1
Administrative Support	1	1	1	DY1Q1
VP of Communications	1	1	1	DY2Q1
Director of Integrated Outreach	1	1	1	DY2Q1
Marketing Coordinator	1	1	1	DY2Q1
Compliance Officer	1	1	1	DY2Q1
Support Staff	0	2	2	DY2Q1
Total DSRIP-Related Positions	81	156	156	DY3Q4

Staffing Gaps: Hospital

Re-Deployment

The Medisys Health System has identified he following staffing gaps:

Titles	Number of Staff
Primary Care Navigators	62
Care Coordinator	1
Managers, Care Navigation	19
ER Registration, Director	1
ER Referral Navigators	8
Patient Navigation Educator	1
ER Pediatrics Nursing	1
Chest Pain Evaluation CTR-NSG	1
Patient Information Representatives	53
Nursing Managers	6
Total	**153**

By the end of DY2Q4 the Medisys ED Triage project team will be fully hired.

Mental Health Depression Care Managers are critical to the successful implementation of project 3ai. **By DY2Q4, 3 Mental Health Depression Care Managers will be hired.**

Training Gaps: PPS

Analysts to complete *Data Analytics* training at the General Assembly Campus in New York City.
By DY2Q2 all Analysts will have completed Data Analytics training

Hire and train Value-Based/Medical Economics Analyst, Data Scientists, IDS Specialist/IT Coordinators
By DY3Q3 all training will be completed

Certify PCMH level 3 content manager experts and PCMH support staff.
By DY2Q4 training will be completed

Hire and train project manager. Project managers to complete online *Master Certificate in Applied Project Management-Healthcare* through Villanova University. Project managers received NCQA HEDIS training.
By DY2Q3 training will be completed

Training Gaps: Medical Practices

Physician Engagement Training

A total of 600 PCPs will be trained by DY2Q4 and an additional 815 by DY3Q4.

Medical Practices Training Plan

- Develop Practitioners training, communication and engagement plan.
- Develop reporting metrics and benchmarks to be used to monitor compliance with DSRIP measures and provide training to practitioners on each measure.

Initial reporting metrics to determine physician performance will include, but not be limited to the following:

- **Attribution Benchmark:** Engagement ratio based on DSRIP attribution
- **Panel Benchmark:** Engagement ratio based on comprehensive panel based on Medicaid and Medicaid Managed Care rosters
- **Care Gaps:** Outstanding HEDIS measures based on diagnosis history of the patient
- **Care Plan Compliance:** Measure of patients with care plans vs total number patients with diagnosis requiring care plans

Physicians will be measured against prior year performance, as well as performance of their peers within similar geographical and specialty areas.

As the transition to Value Based Payments occur, several reports will be developed to train physicians to understand their role including expense and utilization reports that can be drilled down to specific medical expense categories such as Inpatient, Outpatient, and Behavioral Health and Substance Abuse.

On-Going Training of Medical Practices

- Train medical practice staff on project, cardiovascular disease care plans, Million Hearts campaign, blood pressure station, and referral process.

- Train medical practice staff on projects, diabetes care plans, and referral process.

- Train Medical Assistants, or appropriate staff identified by PCP or practice lead, on projects, referral process, and ACP community resource guide.

PCMH Training and Certification

PCMH certification is required for full participation in DSRIP and VBP.

By the end of DY3Q4, 748 providers in 560 practices will be assisted to complete 2014 PCMH level 3 certification.

ACP has identified the network providers that need PCMH transformation services and categorized them into four groups:

ACP has partnered with four PCMH vendors to provide transformation services: CCACO, Insight Management, HQ Analytics, and Precision Quality. Each practice will be assigned a PCMH vendor based on the above categories and their EHR. If the practice/provider has never been PCMH certified, ACP will provide vendor options.

- ACP will manage the PCMH transformation for its network providers from start to finish though the use of tracking tools. A contingency plan has been developed for potential scenarios.
- For practices/providers that choose to seek PCMH 2014 level 3 certification on their own, ACP will offer reimbursement options.
- ACP is developing internal PCMH Certified Content Experts to provide support and expertise to its physician network.
- ACP is developing in-person PCMH training to create a collaborative space where providers can learn from ACP's PCMH certified staff, their peers, participating vendors, etc.

Transformation and Certification Timelines Under the PCMH Process Per Practice:

Task	Timeline
Gap Analysis	1 – 3 weeks (depending on practice size)
On-Site Practice Transformation	30 - 120 days (depending on GAP analysis and number of practice sites)
Application preparation/submission	12 - 15 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

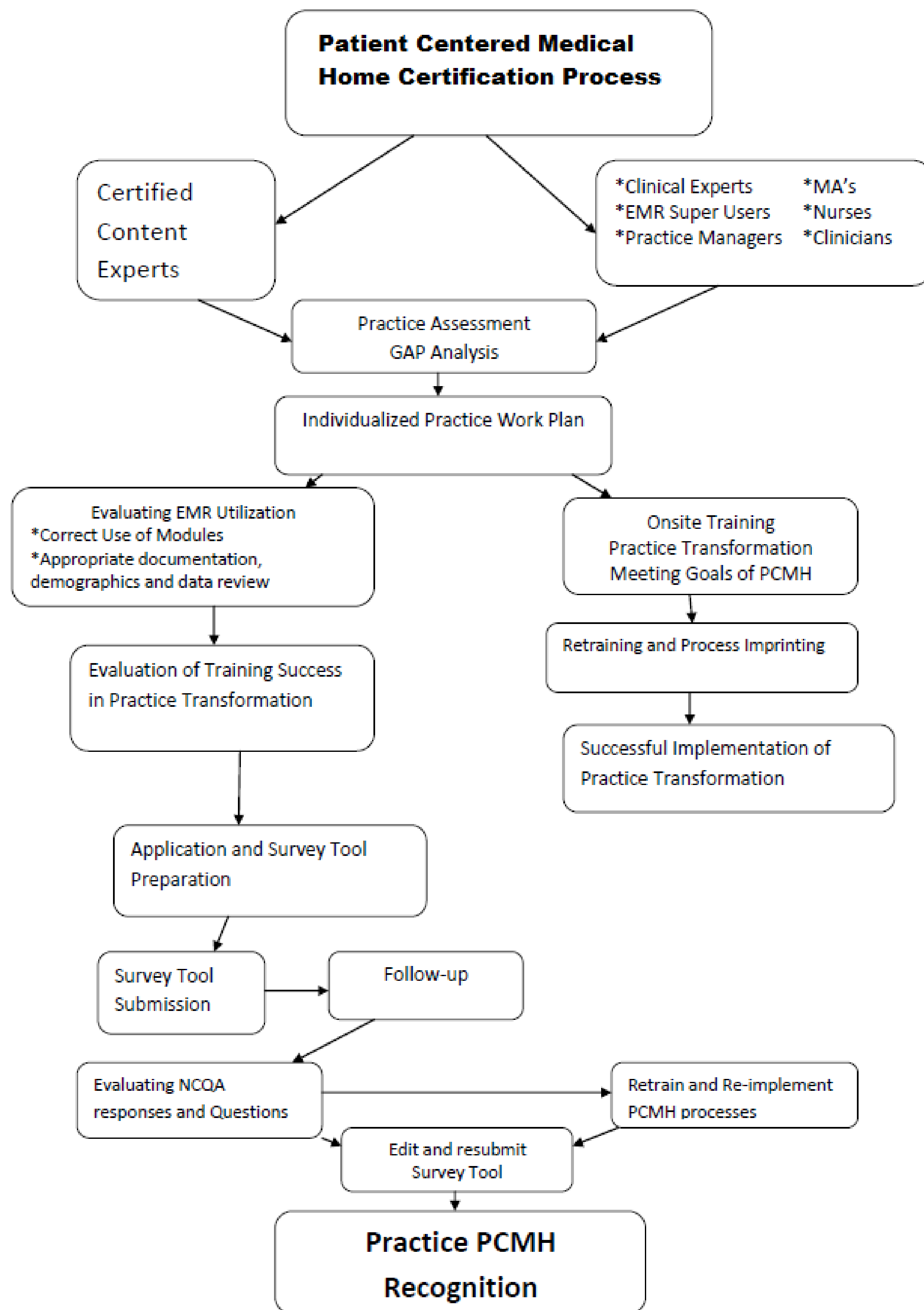
ACP Patient-Centered Medical Home Transformation Gap Analysis

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. PCMH certification impacts on all of ACP's ten DSRIP projects in concert with effective patient care. The certification will also facilitate DSRIP technology and connectivity requirements. Below are the six standards and elements of PCMH:

Standard	Elements
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.


Patient Centered Medical Home Certification Process
Certified Content Experts
*Clinical Experts *MA's
*EMR Super Users *Nurses
*Practice Managers *Clinicians
Practice Assessment GAP Analysis
Individualized Practice Work Plan
Evaluating EMR Utilization
*Correct Use of Modules
*Appropriate documentation, demographics and data review
Onsite Training Practice Transformation Meeting Goals of PCMH
Retraining and Process Imprinting
Evaluation of Training Success in Practice Transformation
Successful Implementation of Practice Transformation
Application and Survey Tool Preparation
Survey Tool Submission
Follow-up
Evaluating NCQA responses and Questions
Retrain and Re-implement PCMH processes
Edit and resubmit Survey Tool
Practice PCMH Recognition

Training Gaps: Hospitals

In order to implement the ED Triage Project 2biii, Health Home at Risk Project 2aiii, and the Care Transition Project 2biv, Medisys identified the following training needs:

Titles	Number of Staff	Timeline for Completion
Primary Care Navigators	62	**DY2Q2**
Care Coordinator	1	**DY2Q2**
Managers, Care Navigation	19	**DY2Q2**
ER Registration, Director	1	**DY2Q2**
ER Referral Navigators	8	**DY2Q2**
Patient Navigation Educator	1	**DY2Q2**
ER Pediatrics Nursing	1	**DY2Q2**
Chest Pain Evaluation CTR-NSG	1	**DY2Q2**
Patient Information Representatives	53	**DY2Q2**
Nursing Managers	6	**DY2Q2**
Total	**153**	**DY2Q2**

Internal resources will be utilized to train for all positions. After training existing staff are re-deployed to new roles in support of the above listed DSRIP projects.

Mental Health Patient Navigators, PCPs and support staff are critical to the successful implementation of project 3ai.

By DY2Q4, 40 Patient Navigators and 25 support staff (i.e. Med Assistants) will be trained and re-deployed to support Project 3ai. In addition, 200 PCPs will be trained by DY2Q2 and an additional 200 PCPs by DY2Q4 in the administration and management of PHQ2 and PHQ9 screening tools.

Training Gaps: All Providers/Hospitals, Medical Practices, CBOs, PPS

DSRIP 1.0 Basic knowledge about DSRIP and VBP

A DSRIP 1.0 curriculum was developed by 1199TEF in conjunction with the PPS. The curriculum will be made available online to all network partners on the HW Apps learning management platform. The course will be made available in DY2Q4.

Health Coaching/Stanford Model

Chronic Disease Self-Management represents an important intervention in addressing the needs of persons living with diabetes, asthma, CVDs and other chronic illnesses. There are hundreds of patients registered through the QTAC website in the ACP target area that are waiting for availability of a self-management workshop. In order to close this gap ACP will engage the entire network in the training and deployment of Stanford Model trained and certified workshop leaders.

Twenty (20) Patient Leaders will be trained by DY2Q3 and an additional 20 by DY2Q4. Workshops will be held in community and medical settings.

Train PNs and CHWs on eligibility guidelines, referral process, and electronic patient tracker. **Training on going**

Educate staff of CBOs and public agencies on ACP PPS and tobacco use intervention strategies. **Training on going**

Community Health Workers Training (CHW) Training Summary

CHWs are trained and deployed to support all 10 ACP Projects. All CHWs participate in training prior to deployment. The training is divided into 3 elements:

- Core Training
- On the Job Training
- Train the Trainer Techniques

In addition, about 25 of 50 CHWs will be trained to implement the Stanford Model for Diabetes and Chronic Disease Self-Management.

Core Intensive Training: 65 hours

Part I Intensive Course

Day 1 (7 hours):
ACP structure
ACP a Performing Provider System (PPS) as part of the Delivery System Reform Incentive Payment (DSRIP)
Introduction to ACP's Projects
Health Concepts and Health disparities
The Role of Community Health Workers (CHWs)

Day 2 (7 hours):
The Helping Relationship
Professionalism and Boundaries
Team Building – The Game of Possibilities

Day 3 (7 hours):
Communication
Readiness to Change and Motivational Interviewing

Day 4 (7 hours)
Patient Engagement and Retention
Outreach Engagement and Referrals Practices and Techniques

Day 5 (7 hours)
Telephone Behavior, Etiquette and Professionalism
Safety in the Field

Part II Half days

Day 6 (4 hours)
The Hotspots
Health literacy: Environmental Assessment of Medical Practices
The Waiting Room Area
Health Week and Community Mapping
Health Committees Project
Community Health Workers and the CBO Partnership Program (CBOPP)
Using the Medical Practice as the Organizing Principle

Day 7 (4 hours)	Culturally Responsive Services Cultural Humility
Day 8 (4 hours)	Home Visitation: Best Practices
Day 9 (4 hours)	Health Care Systems and Entitlements
Day 10 (8 hours)	Introduction to Chronic Diseases Working with Patients Living with Asthma Working with Patients Living with Diabetes Working with Patients Living with Other Chronic Conditions
Day 11 (6 hours)	Administrative Duties Reporting Process and Forms Working Effectively in Interdisciplinary Teams Shadowing a Medical Practice and a PCP

On the Job Training/Train the Trainer

Every week all CHWs participate in 2 additional hours of training focused on reflection of work performed, role-plays, skills development, problem solving, and development of didactic and training techniques in the field. The sessions are facilitated by managerial and supervisory staff as well as by professional trainers and facilitators.

CHWs perform important functions in community outreach, patient engagement, health promotion and education, care coordination, supportive services referrals and follow up, chronic disease self management, and providing training and support in the execution of these functions to staff in medical practices.

Thirty (30) CHWs will be trained and deployed by DY2Q3 and an additional 20 by DY2Q4.