RFA # QPS – 2016-02
HEALTH RESEARCH, INC.

New York State
Department of Health
Office of Quality and Patient Safety
Innovation Center

Request for Applications

Practice Transformation
Technical Assistance Services

KEY DATES

RFA Release Date:	**December 2, 2016**
Questions Due:	**December 16, 2016**
Questions, Answers and Updates Posted:	**December 21, 2016**
Letter of Intent Due:	**January 6, 2017**
Applications Due:	**January 18, 2017 by 4:00 PM**
Contact Name & Address:	**Justin Hausmann** NYS Department of Health Corning Tower, Room 2084 Empire State Plaza Albany, NY 12237 oqps.asu@health.ny.gov

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I. Introduction

Background

In December 2014, Health Research Inc. (HRI)/the New York State Department of Health (NYSDOH) was awarded a $100 million State Innovation Models (SIM) grant by the Centers for Medicare and Medicaid Innovation (CMMI) to implement the State Health Innovation Plan (SHIP) http://www.health.ny.gov/technology/innovation_plan_initiative/. New York has proposed a multidisciplinary approach to health system redesign that includes primary care delivery system and payment reform.

A key component of the SHIP is the development and implementation of an integrated care delivery system with a foundation in Advanced Primary Care (APC). APC describes enhanced capabilities, processes, and performance of primary care providers based on lessons learned from the Comprehensive Primary Care initiative (CPCi), Medicare Advanced Primary Care Program (MAPCP), and National Committee for Quality Assurance (NCQA) Patient Centered Medical Home (PCMH). Each of these initiatives is premised on primary care assuming a central role in the coordination of care. The APC model was developed in concert with numerous external stakeholders who convened regularly as members of the Integrated Care Work Group (ICWG). The ICWG jointly defined the APC framework, which includes:

- **Capabilities** that describe an APC practice;
- **Core Measures** that reflect a practice's impact on patient health, quality of care, and experience;
- **Gates** that define practice capabilities and inform payers for purposes of value-based reimbursement; and
- **Milestones** that define specific expectations of a practice in terms of key capabilities and performance against core measures.

New York State (NYS) is a national leader in the evolution of innovative primary care models including the APC, NCQA PCMH, CPCi, MAPCP and numerous payer-specific models. While additional providers are achieving NCQA PCMH certification each year, they remain a minority: only 25 percent of New York's primary care providers work inside of an NCQA certified PCMH[1], with wide regional variation.

In addition to this SIM funding opportunity, two other programs are providing funding to support changes in primary care toward patient-centered and value-based-payment models. These resources include:

1. The Transforming Clinical Practices Initiative (TCPI) awarded to the New York eHealth Collaborative (NYeC) through the CMMI for practice transformation technical assistance, and
2. Medicaid's Delivery System Reform Incentive Payment (DSRIP) program, which has created multiple "Performing Provider Systems," charged with assuring practices achieve PCMH or APC status.

1 United Hospital Fund, Recent Trends and Future Directions for the Medical Home in New York, 2015

Resources from these programs are not included in this Request for Applications (RFA). HRI/NYSDOH will ensure coordination and collaboration between and among these programs essential to ensure maximum efficiencies.

This RFA seeks applications from responsive and qualified contractors for services related to Practice Transformation (PT) Technical Assistance (TA). The Contractor will function as part of a larger team that is inclusive of primary care (PC) practices, payers, HRI/NYSDOH and an Independent Validation Agent (IVA). The Contractor will assist PC practices and their providers to develop the systems and processes necessary to meet the goals of the "Triple Aim," which are to 1) improve patients' experience of care (including quality and satisfaction); 2) improve the health of populations; and 3) reduce the per capita cost of care.

SIM-funded IVA

The SIM funded IVA, referenced above as part of the larger team, will be separately procured to:

1. Ensure that PC practices' capabilities, as measured by Gates and Milestones, are credible for purposes of continued transformation and payment;
2. Audit PT TA Services Contractors' reported data to ensure validity and reliability; and
3. Collect feedback from PC practices on PT TA Services Contractor performance.

II. Who May Apply

A broad spectrum of applicants are eligible to submit applications, including but not limited to: organizations specializing in PT services, health systems or health plans with experience in assisting with PT, and organizations for which PT is just one component of a suite of other services.

A. Minimum Eligibility Requirements

To meet the RFA's minimum qualifications, applicants must demonstrate the following in their application:

1. Two years of either staff or organizational experience specific to PT;
2. An ability and intent to serve all eligible PC practices within the region they specify or a subset thereof, so long as practice eligibility criteria is clearly defined; and
3. Assurances that SIM funding in no way duplicates other sources of federal PT funding (e.g., TCPI, DSRIP). Applicants in receipt of more than one source of PT support must clearly describe mechanisms used to clearly distinguish between funding sources for purposes of reimbursement and to ensure that practices/providers are not in receipt of more than one funding source for the same activity during the same time frame.

B. Preferred Eligibility Requirements

The successful applicant will document skills and experience in their application relevant to the execution of PT TA services to PC practices and reflecting previous experience with delivering successful PT within the region they specify.

III. Project Narrative/ Work Plan Outcomes

A. Region Selection

Contractors will provide PT TA services, on a regional basis, within regions as defined by the New York Standardized Rating Regions (Attachment 2).

B. Overview of Gates/Milestones

The Contractor will assist PC practices to develop the systems and processes necessary to meet the goals of the "Triple Aim" by leading PC practices through three (3) APC-specific "Gates" with associated Milestones (Attachment 3). The PC practice must fulfill all of the Milestones in each Gate in order to be eligible to move to the next Gate. The Contractor will provide PT TA services to the PC practice for up to two (2) years, depending on the initial readiness of the PC practice, in building capabilities to reach APC goals and to progress through the three Gates.

C. Enrollment of PC Practices and Deliverables

The PT TA Services Contractors will perform the following activities. Applications should address all of the following:

1. The Contractor will provide an initial assessment of PC practices' readiness to receive PT TA services by promoting their provision of PT TA services to PC practices within their specified New York Standardized Rating Region (Attachment 2). The Contractor will provide the "Practice Self-Assessment Tool" (Attachment 6) to the PC practice, along with their contact information at the top of the tool, and request that they complete the tool by a given date and return it to the Contractor. The Contractor will determine readiness and interest in PT, and assess current capacities and PT needs.

2. The Contractor will also request that the PC practice complete and return the signed and notarized "APC Practice Participation Attestation" (Attachment 7). This Attestation must be completed by all PC practice sites, signed by both the Clinical and Business lead persons, and notarized.

3. After the PC practice has fulfilled the enrollment steps above, the Contractor must verify, as part of reviewing the PC practice's Practice Self-Assessment Tool and APC Practice Participation Attestation, that the PC practice is not receiving duplicative PT funding.

4. The Contractor will provide the HRI/NYSDOH Contract Manager with the names, email addresses and phone numbers for their staff who require access to the "PT Tracking System" (PTTS). HRI/NYSDOH will provide the Contractor with user accounts. After the above enrollment steps have been met, the Contractor will enroll the PC practice (on a first-come, first-serve basis) by entering their information into the PTTS and then assist the PC practice to:
    a. Develop and implement a comprehensive work plan that addresses workflows and skill

sets consistent with the Gates and Milestones in Attachment 3;
b. Develop an administrative infrastructure to support alternative payment models; and
c. Develop and implement of a team-based care delivery practice model with high functioning care management and care coordination capabilities.

D. Gating Assessments

The Contractor will be responsible for performing Gate assessments to determine when practices meet APC Milestones and pass APC Gates using the "Gate Assessment Tool" (Attachment 8).

1. Gate 1 – The Contractor will assess the PC practice to:
    a. Confirm strengths and gaps in workforce, infrastructure and workflows related to APC standards and as initially evaluated in the "Practice Self-Assessment Tool;"
    b. Confirm eligibility for PT TA services by the Contractor, financial PT support and commitment to outcomes-based payment models;
    c. Identify the investment and engagement of the PC practice Clinical and Business lead persons in improving the PC practice and willingness to devote sufficient time and resources to successfully participate; and
    d. Provide a basis for determining a tailored, PC practice-specific PT plan.
2. Gates 2 and 3 – Using the "Gate Assessment Tool" (Attachment 8), the Contractor will assess progress toward Gates on an ongoing basis. The Gate assessments are subject to audit and quality control by the IVA. Guidance will be provided to the Contractor to verify accomplishments of PC practices that completed certain Gate 2 Milestones under 1) National Committee for Quality Assurance (NCQA), Patient Centered Medical Home (PCMH) 2014 Standards; 2) Transforming Clinical Practice Initiative (TCPI), Practice Transformation Network (PTN), Practice Assessment Tool (PAT); and/or 3) Electronic Health Record, Meaningful Use, Stage 1 or 2. These accomplishments, when formally verified by the Contractor, may serve as credit for completing the applicable Gate 2 Milestones.

PC Practices Participating in Other PT Programs: For PC practices that have requested a Gate assessment, but do not want PT TA services or are ineligible for PT TA services (e.g., participating in other PT program[s]), the Contractor will conduct a Gate assessment to align PC practice capacities to APC Gates and Milestones using the "Gate Assessment Tool" (Attachment 8).

The Contractor will create mechanisms for the PC practice to facilitate reporting on a standardized or core set of variables that guide payment, incent quality improvement (QI) and facilitate the potential for shared savings.

The Contractor will ensure that the PC practice achieves satisfactory progress toward completing the Milestones. Satisfactory progress is defined according to the PC practice's most recently passed Gate:

1. PC practices fulfilling all of the Milestones in Gate 1 will qualify for up to 12 months of PT TA services from the Contractor to help them demonstrate Gate 2 Milestones.
2. PC practices passing Gate 2 will qualify for up to 12 months of PT TA services to demonstrate Gate 3 Milestones.

The HRI/NYSDOH Contract Manager will make the "APC Scorecard" available to the Contractor. The Contractor will integrate and improve PC practice performance for the Milestones through use of the Scorecard. The Scorecard provides a valid performance profile at the PC practice level that can be used for provider quality improvement and payment determinations across payers.

E. Curriculum Development and Delivery

The Contractor will tailor its curriculum to each individual PC practice in order for the PC practice to achieve the Milestones. The curriculum must be sufficient to advance practices through the Gates within the above timeframes. The proposed curriculum must delineate between activities to be performed by the Contractor and activities to be performed by the PC practice, and will be reflective of the PC practice's past experiences, baseline features and capabilities assessed by the Contractor including those from the "Practice Self-Assessment Tool", and the PC practice's location and size. The curriculum, at a minimum, must include the following seven (7) modules:

a. Introduction to APC;
b. Health Information Technology (HIT);
c. Care coordination and case management;
d. Patient-Centered Care;
e. Practice capability building;
f. Performance in outcome-based payments; and
g. Integration of population and behavioral health care.

Applicants should provide a set of sample units and sample topics to form part of their completed curriculum. The curriculum should address the required modules and sample units described in the "Sample Curriculum" *(*Attachment 4) along with any others the applicant deems necessary; describe the learning modalities to be used in each module, unit and topics; and, describe the topics in greater detail than shown in Attachment 4.

The Contractor will deliver the curricula using at least two (2) of the following methods. The Contractor will select the methods that best fit each individual PC practice for successful PT results.

A. On-site Coaching and Practice Facilitation – The Contractor will visit the PC practice site at least once per month for one-on-one coaching with both the Clinical and Business lead persons. Coaching will center on QI techniques and leadership training. The Contractor will also provide an opportunity for the PC practice office team to discuss progress and challenges that they encountered during the PT TA process.

B. Learning Collaboratives – The Contractor will hold learning collaboratives at least quarterly and will provide the PC practices with a chance to learn from each other, share best practices, collaborate on common problems and adopt evidence-based protocols. These may take place in person, by phone or online.

C. Group Trainings – The Contractor will hold group trainings at least bi-monthly with topics related to PT theories and to be convened with multiple PC practices at the same time. The Contractor will allow time for PC practices to ask questions of the Contractor.

These may take place in person, but are recommended to be webinars.

D. Remote Support – The Contractor will provide remote resources that the PC practice can access at their convenience. This may include recorded webinars or internet-based resources, and will empower the PC practice to become independent in the PT process. The Contractor will ensure that the PC practice is able to contact the Contractor by phone and/or email with questions and to receive a prompt reply.

F. Monitoring and Reporting

On an ongoing basis, the Contractor will monitor each PC practice's progress against the Milestones and will develop and provide remedial learning plans to PC practices at risk of not meeting the above Gate timelines.

1. The Contractor will submit quarterly reports to the HRI/NYSDOH Contract Manager on PC practice achievement of APC Gates and Milestones.

2. The Contractor will immediately notify the HRI/NYSDOH Contract Manager of any potential conflicts with enrolled PC practices (i.e., appearance that the PC practice is receiving PT funding from another source).

3. The Contractor will provide information to, and comply with requests for interviews from, the IVA in order for the IVA to have sufficient oversight of the Gates/Milestones over the course of the statewide PT TA project.

G. Meetings

The Contractor will attend collaborative PT TA meetings conducted by HRI/NYSDOH to share best practices and insights from successful PT efforts with other PT TA Services Contractors. HRI/NYSDOH will also share any updates to the APC model. These meetings will be monthly conference calls and quarterly in-person or videoconference meetings.

H. Records Retention

The Contractor will maintain a file for each PC practice receiving PT TA services and/or a Gate assessment. The Contractor will provide this documentation to the HRI/NYSDOH Contract Manager or IVA as requested.

IV. Administrative Requirements

A. Issuing Agency

This RFA is issued by HRI/ NYSDOH, Office of Quality and Patient Safety, with funding provided by CMMI. HRI/ NYSDOH are responsible for the requirements specified herein and for the evaluation of all applications.

B. Question and Answer Phase:

All substantive questions must be submitted by email to the following address by the date listed on the cover page of this RFA:

oqps.asu@health.ny.gov

To the degree possible, each inquiry should cite the RFA page, section and paragraph number to which it refers. Written questions will be accepted until the date posted on the cover of this RFA. Questions of a technical nature can be addressed in writing to the above email address. **Questions are of a technical nature if they are limited to how to prepare your application (e.g., formatting) rather than relating to the substance of the application.**

Prospective applicants should note that all clarification and exceptions, including those relating to the terms and conditions of the contract, are to be raised prior to the submission of an application, during the question and answer phase, by the date listed on the cover page of this RFA.

This RFA has been posted on HRI's public website at: http://www.healthresearch.org/funding-opportunities. Questions and answers, as well as any updates and/or modifications, will also be posted on HRI's website. All such updates will be posted by the date identified on the cover sheet of this RFA.

C. Letter of Intent

In order to assist HRI/NYSDOH to manage this procurement process, submission of a Letter of Intent is highly encouraged. Please submit a letter of intent to the email address listed above. Letters of Intent/Interest are due by the due date on the cover page of this RFA.

D. Applicant Conference

An Applicant Conference *will* NOT be held for this RFA.

E. How to file an application

Applications must be **received** at the following address by the date and time listed on the cover page of this RFA. Late applications will not be accepted*.

Justin Hausmann
NYS Department of Health
Corning Tower, Room 2084
Empire State Plaza
Albany, NY 12237
oqps.asu@health.ny.gov

Applicants shall submit by mail one (1) original, signed application AND five (5) copies, AND one (1) electronic copy emailed to the address above. Application packages should be clearly labeled with the name and number of the RFA as listed on the cover of this RFA document.

*It is the applicant's responsibility to see that applications are delivered to the mailing and email address above prior to the date and time specified above. Late applications due to documentable delay by the carrier may be considered at HRI's discretion.

F. HRI AND THE DEPARTMENT OF HEALTH RESERVE THE RIGHT TO

1. Reject any or all applications received in response to this RFA.
2. Withdraw the RFA at any time, at HRI's sole discretion.
3. Make an award under the RFA in whole or in part.
4. Disqualify any applicant whose conduct and/or proposal fails to conform to the requirements of the RFA.
5. Seek clarifications and revisions of applications.
6. Use application information obtained through site visits, management interviews and the state's investigation of an applicant's qualifications, experience, ability or financial standing, and any material or information submitted by the applicant in response to the agency's request for clarifying information in the course of evaluation and/or selection under the RFA.
7. Prior to application opening, amend the RFA specifications to correct errors or oversights, or to supply additional information, as it becomes available.
8. Prior to application opening, direct applicants to submit proposal modifications addressing subsequent RFA amendments.
9. Change any of the scheduled dates.
10. Waive any requirements that are not material.
11. Award more than one contract resulting from this RFA.
12. Conduct contract negotiations with the next responsible applicant, should HRI be unsuccessful in negotiating with the selected applicant.
13. Utilize any and all ideas submitted with the applications received.
14. Unless otherwise specified in the RFA, every offer is firm and not revocable for a period of 60 days from the bid opening.
15. Waive or modify minor irregularities in applications received after prior notification to the applicant.
16. Require clarification at any time during the procurement process and/or require correction of arithmetic or other apparent errors for the purpose of assuring a full and complete understanding of an offerer's application and/or to determine an offerer's compliance with the requirements of

the RFA.

17. Negotiate with successful applicants within the scope of the RFA in the best interests of HRI.

18. Eliminate any mandatory, non-material specifications that cannot be complied with by all applicants.

19. Award contracts based on geographic or regional considerations to serve the best interests of HRI.

G. Term of Contract

Any contract resulting from this RFA will be effective only upon final approval by Health Research, Inc.

It is expected that contracts resulting from this RFA will have the following time period: February 1, 2017 through January 31, 2019 (24 months), issued in two (2) yearly increments, on February 1, 2017 and February 1, 2018. Renewals are dependent upon satisfactory performance and continued funding availability.

HRI reserves the right to revise the award amount as necessary due to changes in the availability of funding.

H. Payment & Reporting Requirements of Awardees

1. The contractor shall submit *monthly* invoices to:

   oqps.asu@health.ny.gov

2. The contractor shall submit the following periodic reports:
   - Quarterly reports and monthly/quarterly in-person or videoconference meetings as detailed in this RFA
   - Monthly reports in association with invoicing
   - All payment and reporting requirements will be detailed in Exhibit C of the final contract.

I. General Specifications

1. By signing the "Application Cover Sheet" (Attachment 1), each applicant attests to its express authority to sign on behalf of the applicant.

2. Contractor will possess, at no cost to HRI or the State, all qualifications, licenses and permits to engage in the required business as may be required within the jurisdiction where the work specified is to be performed. Workers to be employed in the performance of this contract will possess the qualifications, training, licenses and permits as may be required within such jurisdiction.

3. Submission of an application indicates the applicant's acceptance of all conditions and terms contained in this RFA, including the terms and conditions of the contract. Any exceptions allowed by HRI during the Question and Answer Phase (Section IV.B.) must be clearly noted in a cover letter attached to the application.

4. An applicant may be disqualified from receiving awards if such applicant or any subsidiary, affiliate, partner, officer, agent or principal thereof, or anyone in its employ, has previously failed to perform satisfactorily in connection with public bidding or contracts.

5. Provisions Upon Default

   a. The services to be performed by the Applicant shall be at all times subject to the direction and control of HRI as to all matters arising in connection with or relating to the contract resulting from this RFA.

   b. In the event that the Applicant, through any cause, fails to perform any of the terms, covenants or promises of any contract resulting from this RFA, HRI shall thereupon have the right to terminate the contract by giving notice in writing of the fact and date of such termination to the Applicant.

6. Applicant must maintain an active registration in the System for Award Management (SAM) at SAM.gov, have no exclusions or delinquent federal debt.

J. HRI Boilerplate Agreement

Applicants awarded funding from this RFA will be expected to agree to the below:

AGREEMENT

THIS AGREEMENT, made as of «Start_Date» (the "Effective Date"), by and between **HEALTH RESEARCH, INC.**, a not for profit corporation organized and existing under the laws of the State of New York, with principal offices located at Riverview Center, 150 Broadway, Ste. 560, Menands, NY 12204, hereinafter referred to as **HRI**, and **«CONSULTANT_NAME»**, located at «Address_One», «Address_Two»«City», «STATE», «Zip», herein after referred to as the **CONSULTANT**.

WITNESSETH

WHEREAS, HRI has been awarded a grant from «Sponsor_Name» for the conduct of a project entitled "«Project_Title»"; and,

WHEREAS, funding for the project, in whole or in part, is provided under a federal government grant or contract; and,

WHEREAS, HRI desires the Consultant's performance of certain services for HRI in connection with such project; and,

WHEREAS, Consultant has represented to HRI that "he/she/it" is competent, willing and able to perform such services for HRI.

NOW THEREFORE, in consideration of the promises, mutual covenants, and agreements contained herein, it is mutually agreed by and between the respective parties as follows:

1. Consultant agrees to perform, as an independent contractor and not as an employee or agent of HRI, all the services set forth in Exhibit "A", appended hereto and made a part hereof, to the satisfaction of HRI's Principal Investigator, «PI_Name».

2. The Agreement shall be effective and allowable costs may be incurred by the Consultant from the Effective Date and shall continue until «End_Date» (the "Term") unless terminated sooner as hereinafter provided or extended by written agreement of the parties.

3. In full and complete consideration of Consultant's performance hereunder, HRI agrees to compensate Consultant pursuant to the breakdown in Exhibit "A" attached. Final invoices are due within 60 days of the termination date of this Agreement. Requests received after this 60-day period may not be honored. Any reimbursement payable hereunder by HRI to the Consultant shall be subject to retroactive reductions and/or repayment for amounts included therein which are identified by HRI, on the basis of any review or audit, to not constitute an allowable cost or charge hereunder.

4. The Scope of Work and Budget in Exhibit "A" may be modified as conditions warrant by mutual agreement between HRI and Consultant, and confirmed in writing. In no event shall the total consideration under this Agreement exceed Total Contract Amount Typed Out Dollars ($«Total_Contract_Amt_In_Numbers»).

5. Consultant acknowledges and agrees that all work products, deliverables, designs, writings, inventions, discoveries, and related materials, (collectively “Works”) made, produced or delivered by Consultant in the performance of its obligations hereunder will be owned exclusively by HRI. All copyrightable Works are "works made for hire". Consultant will assign, and hereby assigns and transfers, to HRI all intellectual property rights in and to Works, including without limitation, copyrights, patent rights, trademark rights, and trade secret rights. Consultant further agrees that "he/she/it" shall not claim or assert any proprietary interest in any of the data or materials required to be produced or delivered by Consultant in the performance of its obligation hereunder. Consultant warrants that all Works shall be original except for such portion from copyrighted works as may be included with Consultant’s advance permission of the copyright owner(s) thereof, that it shall contain no libelous or unlawful statements or materials, and will not infringe upon any copyright, trademark or patent, statutory or other proprietary rights of others. Consultant further agrees that "he/she/it" will not publish, permit to be published, or distribute for public consumption, any information, oral or written, concerning the results or conclusions made pursuant to this Agreement without the prior written consent of HRI.

6. Neither party shall use the name of the other or any adaptation, abbreviation or derivative of any of them, whether oral or written, without the prior written permission of the other party. For the purposes of this paragraph "party" on the part of HRI shall include the State of New York and the NYS Department of Health.

7. It is understood and agreed that the services to be rendered by Consultant are unique and that Consultant shall not assign, transfer, subcontract or otherwise dispose of its rights or duties hereunder, in whole or in part, to any other person, firm or corporation, without the advance written consent of HRI.

8. The nature of the relationship which the Consultant shall have to HRI pursuant to this Agreement shall be that of an independent contractor. Under no circumstance shall the Consultant be considered an employee or agent of HRI. This Agreement shall not be construed to contain any authority, either expressed or implied, enabling the Consultant to incur any expense or perform any act on behalf of HRI.

9. Consultant is solely responsible for complying with all applicable laws, including but not limited to those specified in Appendix “A”, and obtaining, at Consultant’s sole expense, any and all licenses, permits, or authorizations necessary to perform services hereunder.

10. This Agreement shall be void and no force and effect unless Consultant shall provide and maintain coverage during the life of this Agreement for the benefit of such employees as are required to be covered by the provisions of Workers’ Compensation Law.

11. Unless otherwise agreed by HRI, Consultant shall maintain, or cause to be maintained, during the Term of this Agreement, insurance or self-insurance equivalents of the following types and amounts: a) Commercial General Liability (CGL) with limits of insurance of not less than $1,000,000 each occurrence and $2,000,000 annual aggregate: b) HRI and the People of the State of New York shall be included as Additional Insureds on the Consultant’s CGL, using ISO Additional Insured Endorsement CG 20 10 11 85 or an endorsement providing equivalent coverage to the Additional Insureds. The CGL insurance for the Additional Insureds shall be as broad as the coverage provided for the Named

Insured Consultant. It shall apply as primary and non-contributing insurance before any insurance maintained by the Additional Insureds; c) other such insurance as may be specified by HRI, depending on the project and services provided by Consultant.

12. Consultant shall establish and maintain complete and accurate books, records, documents, accounts and other evidence directly pertinent to performance of the services under this Agreement (collectively, “Records”). The Records must be kept for the balance of the calendar year in which they are created and for six years thereafter. HRI shall have reasonable access to such Records as necessary for the purposes of inspection, audit, and copying. Records shall be maintained as Confidential Information and protected from public disclosure.

13. This Agreement, including all applicable attachments and appendices thereto, represents the entire Agreement and understanding of the parties hereto and no prior writings, conversations or representations of any nature shall be deemed to vary the provisions hereof. This Agreement may not be amended in any way except in writing, duly executed by both parties hereto.

14. HRI may terminate this Agreement with or without cause at any time by giving advance notice, when, in its sole discretion, HRI determines that it is in the best interests of HRI to do so, or as directed by the project sponsor. Such termination shall not affect any commitments which, in the judgment of HRI, have become legally binding prior to the effective date of termination. Upon termination of the Agreement by either party for any reason, Consultant shall immediately turn over to HRI any works in progress, materials, and deliverables (whether completed or not) related to the services performed up to the date of termination. It is understood and agreed, however, that in the event that Consultant is in default upon any of its obligations, hereunder, at the time of such termination, such right of termination on the part of HRI shall expressly be in addition to any other rights or remedies which HRI may have against Consultant by reason of such default.

15. Consultant acknowledges and agrees that, during the course of performing services for HRI, it may receive information of a confidential nature, whether marked or unmarked (“Confidential Information”). Consultant agrees to protect such Confidential Information with the same degree of care it uses to protect its own confidential information of similar nature and importance, but with no less than reasonable care. Consultant will not use Confidential Information for any purpose other than to facilitate the provision of services under this Agreement, and Consultant will not disclose Confidential Information to any third party without HRI’s advance written consent.

16. Consultant represents and warrants that: a) it has the full right and authority to enter into and perform under this Agreement; b) it will perform the services set forth in Exhibit "A" in a workmanlike manner consistent with applicable industry practices; c) the services, work products, and deliverables provided by Consultant will conform to the specifications in Exhibit "A"; d) there is no pending or threatened claim or litigation that would have a material adverse impact on its ability to perform as required by this Agreement.

17. Consultant shall have no interest, financial or otherwise, direct or indirect, or engage in any business, transaction, or professional activity, that may create a conflict with the proper discharge of Consultant’s duties under this Agreement. In the event any actual or potential conflict arises, Consultant agrees to notify HRI in writing within ten (10) days to allow HRI to evaluate any potential impact on Consultant’s performance under this Agreement.

18. Consultant agrees to defend, indemnify and hold HRI, its agents and employees, the New York State Department of Health, and the People of the State of New York, harmless from any losses, claims, damages, expenses, and liabilities (including reasonable attorneys’ fees arising out of: (i) any act or omission by Consultant in connection with the performance of services constituting negligence, willful misconduct, or fraud; (ii) the breach of the confidentiality obligations set forth herein; (iii) any claim for compensation or payment asserted by any employee or agent of Consultant; (iv) Consultant’s failure to carry out Consultant’s responsibilities under this Agreement; (v) any intellectual property infringement or misappropriation by Consultant in connection with the services provided under this Agreement.

19. Should any provision of this Agreement be proven to be invalid or legally ineffective, the overall validity of this Agreement shall not be affected. Unless the parties agree on an amended provision, the invalid provision shall be deemed to be replaced by a valid provision accomplishing as far as possible the purpose and intent of the parties at the date of the Agreement.

20. The failure of HRI to assert a right hereunder or to insist on compliance with any term or condition of this Agreement shall not constitute a waiver of that right of HRI, or other rights of HRI under the Agreement, or excuse a subsequent failure to perform any such term or condition by Consultant.

21. This Agreement shall be governed and construed in accordance with the laws of the State of New York. The jurisdictional venue for any legal proceedings involving this Agreement shall be in the State of New York. Disputes involving this Agreement may not be submitted to binding arbitration.

22. In addition to the methods of process allowed by the State Civil Practice Law & Rules (CPLR), in any litigation arising under or with respect to this Agreement, Consultant hereby consents to the service of process upon it by registered or certified mail, return receipt requested, and will promptly notify HRI in writing in the event there is any change of address to which service of process can be made.

23. This Agreement may be executed in two or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. Delivery of an executed signature page to the Agreement by facsimile transmission or PDF shall be as effective as delivery of a manually signed counterpart.

24. Consultant agrees to abide by the terms and conditions of Appendix "A" attached hereto and made a part hereof, including the provisions required for federally funded projects, if applicable.

HEALTH RESEARCH, INC.
APPENDIX A to AGREEMENT WITH ENTITY

The parties to the attached Agreement further agree to be bound by the following terms, which are hereby made a part of said Agreement:

1. During the performance of the Agreement, the Consultant agrees as follows:

   (a) Equal Opportunity and Non-Discrimination - Consultant acknowledges and agrees, whether or not required by Article 15 of the New York State Executive Law (also known as the Human Rights Law) or any other State or Federal statutory or constitutional non-discrimination or civil rights provisions, including but not limited to the American Disabilities Act, that Consultant will not discriminate against any employee or applicant for employment because of race, color, creed, religion, sex, sexual orientation, gender identity, national origin, age, disability, pregnancy-related condition, military or veteran status, genetic predisposition or carrier status, marital or familial status, domestic violence victim status, individual's relationship or association with a member of a protected category or any other basis protected by state and federal law. Furthermore, Consultant agrees that neither it nor its authorized subcontractors, if any, shall, by reason of race, color, creed, religion, sex, sexual orientation, gender identity, national origin, age, disability, pregnancy-related condition, military or veteran status, genetic predisposition or carrier status, marital or familial status, domestic violence victim status, individual's relationship or association with a member of a protected category or any other basis protected by applicable state and federal law: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under this Agreement. Consultant is subject to Section 220-e or Section 239 of the New York State Labor Law for work performed under this Agreement. Pursuant thereto, Consultant is subject to fines of $50.00 per person per day for any violation of this provision, which may be deducted from any amounts payable under this Agreement, as well as possible termination of this Agreement and forfeiture of all moneys due hereunder for a second or subsequent violation.

   (b) This contractor and subcontractor shall abide by the requirements of 41 CFR 60-1.4(a) which is hereby incorporated herein.

This contractor and subcontractor shall abide by the requirements of 41 CFR 60-741.5(a). This regulation prohibits discrimination against qualified individuals on the basis of disability, and requires affirmative action by covered prime contractors and subcontractors to employ and advance in employment qualified individuals with disabilities.

This contractor and subcontractor shall abide by the requirements of 41 CFR 60-300.5(a). This regulation prohibits discrimination against qualified protected veterans, and requires affirmative action by covered prime contractors and subcontractors to employ and advance in employment qualified protected veterans.

(c) System for Award Management (SAM) - Consultant is required to register with SAM.gov and maintain active status as stated in 2 CFR Subtitle A, Chapter 1, and Part 25 of Code of Federal Regulations. **Consultant** must maintain the accuracy/currency of the information in SAM at all times during which your entity has an active agreement with HRI. Additionally, your entity is required to review and update the information at least annually after the initial registration, and more frequently if required by changes in your information.

2. Assurances Required by DHHS--HHS (Where Applicable)

(a) Human Subjects, Derived Materials or Data
The Consultant and HRI both agree to abide by DHHS regulations concerning Human Subjects. The DHHS regulation, 45 CFR 46, provides a systematic means, based on established ethical principles, protecting the rights and welfare of individuals who may be exposed to the possibility of physical, psychological or social injury while they are participating as subjects in research, development or related activities. The regulation extends to the human fetus (either in utero or ex utero), the dead, organs, tissues, and body fluids, and graphic, written or recorded information derived from human sources.

The DHHS regulation requires institutional assurances, including the implementation of procedures for review, and the assignment of responsibilities for adequately protecting the rights and welfare of human subjects. Safeguarding these rights and welfare is, by DHHS policy, primarily the responsibility of the grantee. The Consultant is responsible for ensuring that the activity described or covered by this Agreement, and additional information relating to human subjects, derived materials or data are annually reviewed and approved by the Institutional Review Board of the Consultant. The Consultant and HRI agree to complete a HHS 596 form on an annual basis.

(b) Laboratory Animals
The Consultant agrees to abide by HHS policy requiring that laboratory animals not suffer unnecessary discomfort, pain or injury. The Consultant must assure HHS, in writing that it is committed to following the standards established by the Animal Welfare Acts and by the documents entitled “Principles for Use of Animals “and” Guide for the Care and Use of Laboratory Animals."

(c) Recombinant DNA
The Consultant agrees to abide by the current HHS Guidelines for Research involving Recombinant DNA Molecules. All research involving recombinant DNA techniques that is supported by the Public Health Service must meet the requirements of these Guidelines, which were developed in response to the concerns of the scientific and lay communities about the possible effects of recombinant DNA research. Their purpose is to specify practices for the construction and handling of recombinant DNA molecules and organisms or viruses containing recombinant DNA. As defined by the Guidelines, "recombinant DNA" corresponds to: (1) molecules that are constructed outside living cells by joining natural or synthetic DNA segments to DNA molecules that can replicate in a living cell; or (2) DNA molecules that result from the replication of a molecule described in (1).

Several types of studies involving recombinant DNA are exempt from the Guidelines while others are prohibited by the Guidelines. For the remainder, the Consultant must establish and implement policies that provide for the safe conduct of the research in full conformity with the Guidelines. This

responsibility includes establishing an institutional biosafety committee to review all recombinant DNA research to be conducted at or sponsored by the Consultant and to approve those projects that are in conformity with the Guidelines. For each approved project, a valid Memorandum of Understanding and Agreement (MUA) shall be prepared for submission when solicited by an appropriate HHS staff member. The MUA is considered approved after review and acceptance by ORDA and by the Consultant.

(d) Promoting Objectivity in Research
Neither Consultant nor anyone working on its behalf shall have any interest, financial or otherwise, direct or indirect, or engage in any business, transaction, or professional activity that may create a conflict, or the appearance of a conflict, with the proper discharge of Consultant's duties under this Agreement or the conflict of interest policy of any agency providing federal funding under this Agreement. In the event any actual or potential conflict arises, Consultant agrees (i) to notify HRI in writing within ten (10) days to allow HRI to evaluate any potential or actual conflict, and, (ii) if required, eliminate the conflict or put in place an acceptable conflict management plan. Consultant agrees to comply with the DHHS/HHS regulatory requirements on Responsibility of Applicants for Promoting Objectivity in Research and financial conflicts of interest set forth in 42 CFR Part 50 Subpart F, as may be amended from time to time. Failure to disclose conflicts or provide information related thereto to HRI may be cause for termination of the Agreement

(e) Additional Assurances
Should any additional DHHS-HHS regulations be promulgated that are applicable to this Agreement, the Consultant and HRI will review and agree to include them as part of this Agreement.

The following provisions 3-6 are applicable to federally funded projects:

3. Clean Air Act and the Federal Water Pollution Control Act Compliance - If this Agreement is in excess of $150,000, Consultant agrees to comply and to require that all subcontractors comply, where applicable, with all applicable standards, orders or regulations issued pursuant to the Clean Air Act (42 U.S.C. § 7401-7671q.) and the Federal Water Pollution Control Act as amended (33 U.S.C. §1251-1387). Violations must be reported to the Federal awarding agency and the Regional Office of the Environmental Protection Agency (EPA).

4. Notice as Required Under Public Law 103-333 - The Consultant is hereby notified of the following statement made by the Congress at Section 507(a) of Public Law 103-333 (The DHHS Appropriations Act, 1995, hereinafter the "Act"): It is the sense of the Congress that, to the greatest extent practicable, all equipment and products purchased with funds made available in this Act should be American-made.

5. Required Federal Certifications -Acceptance of this Agreement by Consultant constitutes certification by the Consultant of all of the following:

(a) The Consultant is not presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from covered transactions by any Federal department or agency.

(b) The Consultant is not delinquent on any Federal debt.

(c) The Consultant will comply with the Byrd Anti-Lobbying Amendment (31 U.S.C. § 1352) requiring for Agreements of $100,000 or more, that Consultant (i).will not and has not used Federal appropriated funds to pay any person or organization for influencing or attempting to influence an officer or employee of any agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any Federal contract, grant or any other award covered by 31 U.S.C. § 1352, and (ii) will disclose any lobbying with non-Federal funds that takes place in connection with obtaining any Federal award. Such disclosures are forwarded from tier to tier up to the non-Federal award.

(d) The Consultant shall comply with the requirements of the Pro-Children Act of 1994 and shall not allow smoking within any portion of any indoor facility used for the provision of health, day care,

early childhood development, education or library services to children under the age of eighteen (18) if the services are funded by a federal program, as this Agreement is, or if the services are provided in indoor facilities that are constructed, operated or maintained with such federal funds.

(e) The Consultant has established administrative policies regarding Scientific Misconduct as required by the Final Rule 42 CFR Part 93, Subpart A as published at the 54 Federal Register 32446, August 8, 1989.

(f) The Consultant maintains a drug free workplace in compliance with the Drug Free Workplace Act of 1988 as implemented in 45 CFR Part 76.

(g) If the Project Sponsor is either an agency of the Public Health Service or the National Science Foundation, the Consultant is in compliance with the rules governing Objectivity in Research as published in 60 Federal Register July 11, 1995.

6. Whistleblower Policy - Congress has enacted whistleblower protection statue 41 U.S.C. 4712, which applies to all employees working for contractors, grantees, subcontractors, and sub-grantees on federal grants and contracts. This program requires all grantees, sub-grantees and subcontractors to: inform their employees working on any federally funded award they are subject to the whistleblower rights and remedies of the program; inform their employee in writing of employee whistleblower protections under 41 U.S.C. 4712 in the predominant native language of the workforce; and Contractors and grantees will include such requirements in any agreement made with a subcontractor or sub-grantee.

   The statue (41 U.S.C. 4712) states that an "employee of a contractor, subcontractor, grantee [or sub-grantee] may not be discharged, demoted, or otherwise discriminated against as a reprisal for "whistleblowing". In addition, whistleblower protections cannot be waived by any agreement, policy, form, or condition of employment.

   Whistleblowing is defined as making a disclosure "that the employee reasonably believes is evidence of any of the following: gross mismanagement of a federal contract or grant; a gross waste of federal funds; an abuse of authority relating to a federal contract or grant; a substantial and specific danger to public health or safety; or a violation of law, rule, or regulation related to a federal contract or grant (including the competition for, or negotiation of, a contract or grant). To qualify under the statute, the employee's disclosure must be made to: a Member of Congress or a representative of a Congressional committee; or an Inspector General; or the Government Accountability Office; or a Federal employee responsible for contract or grant oversight or management at the relevant agency; or an authorized official of the Department of Justice or other law enforcement agency; or a court or grand jury; a management official or other employee of the contractor, subcontractor, grantee or sub-grantee who has the responsibility to investigate, discover or address misconduct.

   The Consultant shall require that the language of all of the above certifications will be included in the award documents for all subawards under this Agreement (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

The Consultant agrees to notify HRI immediately if there is a change in its status relating to any of the above certifications.

V. Completing the Application

Applicants proposing to serve <u>more than one</u> region must submit a <u>separate application</u> for each region.

A. Application Content

The following outlines the information to be provided, in the following order, by applicants. Applications that do not follow the prescribed format may be eliminated from consideration.

Program Summary (2 pages maximum, NOT scored)

The work to be completed should meet the RFA purpose and contract scope of work as outlined in Section I and III.

- Applicants should provide a high-level overview of their organization including how it meets the minimum qualifications outlined in Section II of this RFA, as well as an overview of the number and size of PC practices to be served, a proposed plan for providing PT TA services in the proposed region including how the applicant has the capacity to serve the proposed PC practices, and the anticipated time frames for completing the major components of its PT TA services work.
- Applicants should assume a 24-month project period beginning on February 1, 2017 with one annual renewal issued on February 1, 2018.

Application Contents (55 pages maximum, 80 points)

Qualifications (1 page, Pass/Fail)

1. Two years of either staff or organizational experience specific to PT;
2. An ability and intent to serve all eligible PC practices within the region they specify or a subset thereof, so long as practice eligibility criteria is clearly defined; and
3. Assurances that SIM funding in no way duplicates other sources of federal PT funding (e.g., TCPI, DSRIP). Applicants in receipt of more than one source of PT support must clearly describe mechanisms used to clearly distinguish between funding sources for purposes of reimbursement and to ensure that practices/providers are not in receipt of more than one funding source for the same activity during the same time frame.

Region to be covered (1 page, NOT scored):

1. The applicant should specify the DFS Region they are applying to serve.
2. Applicants proposing to serve more than one region should submit a separate application for each region.
3. For each region the applicant intends to serve, they should attest that:

- The applicant is willing to serve all of the eligible PC practices in the region, or
- The applicant is willing to serve only certain PC practices in a region and must explicitly define those practices, how they are/were selected and how additional practices will be selected in the future.

PT TA Services Processes (23 pages maximum, 35 points):

Applicants should describe their approach, including administrative, operational and technical activities, resources and workflows, in the areas below and as described in Section III for delivering PT TA services to PC practices, to support PC practices achieving APC Gates and Milestones. Specific regional specializations, resources or other advantages should be addressed within this section where they are applicable.

A. Regional Selection

A description of how the applicant chose the selected region, including an overview of regional specializations, resources or other advantages.

B. Gates Milestones

A description of the systems and processes the applicant plans to use in order to assist PC Practices advance through APC –specific Gates.

C. Enrollment of PC Practices and Deliverables

1. A description of how the applicant will independently identify practices for transformation, deliver and facilitate accurate completion of the "Practice Self-Assessment Tool" to/by PC practices, and how the applicant will complete an initial assessment of the PC practice and gauge readiness to receive PT TA services.
2. A description of how the applicant will deliver and ensure appropriate completion of the

"APC Practice Participation Attestation" by PC practices.

3. A description of the applicant's process for reviewing the PC practice's Practice Self-Assessment Tool, APC Practice Participation Attestation, and any other steps taken to ensure a PC practice is not receiving duplicative PT funding.
4. A detailed description of how the applicant will assist the PC practice to:
    a. Develop and implement a comprehensive work plan that addresses workflows and skill sets consistent with the Gates and Milestones in Attachment 3;
    b. Develop an administrative infrastructure to support alternative payment models; and
    c. Develop and implement a team-based care delivery practice model with high functioning care management and care coordination capabilities

D. Gating Assessments

1. A detailed description of how the applicant will perform Gate Assessments for practices receiving PT TA services, using the "Gate Assessment Tool" (Attachment 8) to monitor the progress toward and determine when PC practices meet APC Milestones and pass APC Gates.
2. A detailed description of how the applicant will perform Gate Assessments for practices NOT receiving PT TA services, using the "Gate Assessment Tool" (Attachment 8) to measure a PC practices capacities against the APC Milestones and APC Gates.
3. A detailed description of how the applicant will create mechanisms for the PC practice to facilitate reporting on a standardized or core set of variables that guide payment, incent quality improvement (QI) and facilitate the potential for shared savings.
4. A detailed description of how the applicant will ensure that the PC practice achieves satisfactory progress toward completing the Milestones.

E. Curriculum Development and Delivery

1. A detailed description of the applicant's proposed curriculum as described in Section III, E.
2. A detailed description of the process the applicant will use to tailor its curriculum to each individual PC practice
3. A detailed description of how the applicant will deliver the curricula, including the process used by the applicant to determine which method of delivery to utilize.

F. Monitoring and Reports

A detailed description of how the applicant will monitor each PC practice's progress against the Milestones, and how the applicant will develop and provide a remedial learning plan to PC practices at risk of not meeting Gate timelines.

1. A detailed description of how the applicant will collect and monitor the information contained in reports to be provided to HRI/NYSDOH on a quarterly basis.
2. A description of how the applicant will plan for confirming and reporting PC practices with previously undetected, potentially duplicative PT funding.

G. Meetings

A description of how the applicant will evaluate their provision of PT TA services to PC practices and identify best practices to be shared with HRI/NYSDOH.

H. Records Retention

A description of the file the applicant will keep on each PC practice receiving PT TA services

and/or Gate assessments, a description of how and where it will be stored, and an estimated time for providing it to HRI/NYSDOH upon request.

Applicant Experience and Staffing Plan (15 pages maximum, 10 points)

Applicants will be evaluated based on the experience and capabilities of their staff. Applicants should provide information on the key personnel who they are proposing to support this contract. This section should include:

- Short biographies including names, relevant experience and capabilities for each individual, including on-the-ground PT TA Services staff, management support, and subject matter experts. Include the number of hours per week that each staff person will dedicate specifically to this contract. Resumes should be included at the end of this application section, but do not count toward the page limit.
- Job descriptions and hiring criteria (e.g., minimum education and experience requirements) for new positions to be hired, including the number of hours per week that each staff person will dedicate specifically to this contract.
- An organizational chart that shows the management structure of the applicant organization, where the PT TA Services contract will fall within the organizational structure and the reporting structure of PT TA Services staff.
- A sample organizational chart from the perspective of a single enrolled PC practice, including information describing how many Contract personnel by title are dedicated to the practice, both in the field and central expertise, and the percentage of time each staff person is dedicating to the PC practice.
- Description of the region-specific advantages, if any, the applicant has in its staffing approach to the region it is proposing to serve.

Applicants will be evaluated in part based upon their prior experience in PT. Applicants should provide up to five (5) examples of past experiences in PT within the past five (5) years. These should include:

- Number of practices served and during what time period;
- Summary of overall goals and scope of services provided, including ways in which the scope and approach were similar to or different from the scope of this RFA;
- Approach and key learnings generated from the experience;
- Outcomes achieved; and
- If the applicant is a provider organization, they should describe whether the PT TA was for its own and/or affiliated providers, or if the PT TA was for unaffiliated providers.

Description of the region-specific experience, if any, the applicant had in its prior PT experience.

Conflict of interest declaration and management plan (1 page maximum, 5 points)

Applicants will be evaluated in part based upon their ability to provide all of their enrolled practices with an appropriate level of service, regardless of the potential conflicts of interest that they may have. For instance, health systems may have a conflict of interest in enrolling unaffiliated practice sites, and should describe how they will ensure that these unaffiliated practices receive comparable levels of service and support as enrolled practices affiliated with the health plan. Similarly, payers may serve a range of practices, some of which will have a high proportion of members and some of which may have no members, and they should describe how they will ensure that all enrolled practices will receive comparable levels of support.
Specifically, applicants are expected to:

- Declare known and potential conflicts of interest, including with whom and the nature of the conflict
- Present a plan to address, preempt or mitigate these conflicts
- Attest that they will operate in a conflict-free way

Underserved populations and regions plan (4 pages maximum, 10 points).

Applicants will be evaluated in part based on their ability to engage PC practices that serve underserved populations and regions.

- For the purposes of this application, medically underserved populations and regions are defined as those designated as Health Professional Shortage Areas for Primary Care by the Health Resources and Services Administration (HRSA) (http://datawarehouse.hrsa.gov/tools/analyzers/hpsafind.aspx). These areas are defined by a shortage of primary care doctors relative to the population, but the PC needs of each community will vary according to its unique characteristics.
- Competitive applications will include plans that illustrate:
    a. Description of the applicant's abilities to address the region's distinct challenges
    b. Description of previous experience serving underserved populations in the region

Description of the region-specific advantages, if any, the applicant has in serving underserved populations and/or the regions outlined in Attachment 2

Contractor Operations and Timeline (5 pages maximum, 10 points)

Applicants will be evaluated in part based on their ability to developing the capacity to provide the level of services described throughout their application. The plan should include:

- Overall detailed timeline in association with the contract period
- Challenges anticipated and ways in which they will be resolved

Description of any previous experience in rapidly reaching scale and how lessons learned will translate to this Contract

Approach to population health goals of APC (5 pages maximum, 10 points)

Applicants should demonstrate how they will support the population health goals of APC as part of the overarching curriculum. Specific regional specializations, resources or other advantages should be addressed within this section where they are applicable. Applicants should describe:

- Their approach to supporting PC practices in delivering clinical preventive services that help achieve New York's Prevention Agenda goals (https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/)

- Their approach to helping PC practices strengthen community linkages and partnerships to improve delivery of clinical services and increase the use of effective community interventions. These include chronic disease self-management programs and National Diabetes Prevention Programs, and connecting patients to resources and supports that can help maintain health (e.g., connecting high-risk pregnant patients to home visiting services, implementing or referring patients to self-management classes for those with chronic disease, connecting patients with asthma to local health departments to conduct home assessments of environmental asthma triggers, connecting patients with community resources such as food and shelter to improve their health)

- Their approach to assisting PC practices to identify and support activities of the local county Prevention Agenda coalition that is working on community wide strategies to achieve locally selected Prevention

Agenda goals. Local health department contacts can be found at: https://www.health.ny.gov/prevention/prevention_agenda/contact_list.htm

- The operating model for how applicant staff will provide expertise and coaching to all PC practices being served by the applicant
- Any region-specific advantages the applicant has in approaching the population health goals of APC

Budget (2 pages maximum, 20 points)

See and use Attachment 5.

B. Application Format

ALL APPLICATIONS MUST CONFORM TO THE FORMAT DESCRIBED BELOW. POINTS WILL BE DEDUCTED FROM APPLICATIONS WHICH DEVIATE FROM THE DESCRIBED FORMAT.

Applications MUST NOT exceed 57 single -spaced typed pages (not including the cover page, budget and attachments), using 11pt Times New Roman font. The value assigned to each section is an indication of the relative weight that will be given when scoring your application.

1. Program Summary	*2 page maximum*	*(not scored)*
2. Application Contents	*(55-page maximum)*	*(Maximum Score: 80 points)*
3. Budget	*(Use Attachment 5)*	*(Maximum Score: 20 points)*

C. Review Process

Applications meeting the guidelines set forth above will be reviewed and evaluated competitively by HRI/NYSDOH.

In the event of a tie score, the highest scoring applicants will be invited to an interview to last for no longer than one hour in Albany, New York. Any cost related to this meeting or in response to this RFA is the obligation of the applicant. Applications failing to provide all response requirements or failing to follow the prescribed format may be removed from consideration or points may be deducted.

It is anticipated that there will be one or more awards per region. An applicant may be awarded more than one region. The applications receiving the highest score in the region will receive the award.

HRI/NYSDOH reserves the right to determine the number of awards per region. Applications will be reviewed using the criteria listed under "Application Content."

If changes in funding amounts are necessary for this Contract, funding will be modified and awarded in the same manner as outlined in the award process described above.

Once an award has been made, applicants may request a debriefing of their application. The debriefing will be limited only to the strengths and weaknesses of the subject application and will not include discussion of other applications. Requests must be received no later than ten (10) business days from the date of the award or non-award announcement.

VI. Attachments

Attachment 1: Application Coversheet
Attachment 2: New York Standardized Rating Regions
Attachment 3: Gates and Milestones
Attachment 4: Sample Curriculum
Attachment 5: Budget Instructions
Attachment 6: Practice Self-Assessment Tool
Attachment 7: APC Practice Participation Attestation
Attachment 8: Gate Assessment Tool
Attachment 9: Quarterly Reports

Attachment 1

Application Cover Sheet

PT TA Services RFA
RFA# QPS-2016-01

Applicant:

_____

Tax Identification Number: Duns & Bradstreet Number:

_____

Contact Person:

Name

_____

Title

_____

Address

_____

_____

Phone
( )

_____

Email

_____

Total Application Budget: _____

I, _____, for and on behalf of the applicant organization, signify that the following information is true and accurate to the best of my knowledge and that the above named network/organization agrees to abide by the content of this application and is fully able and willing to carry out the contract.

_____

Signature

_____

Name

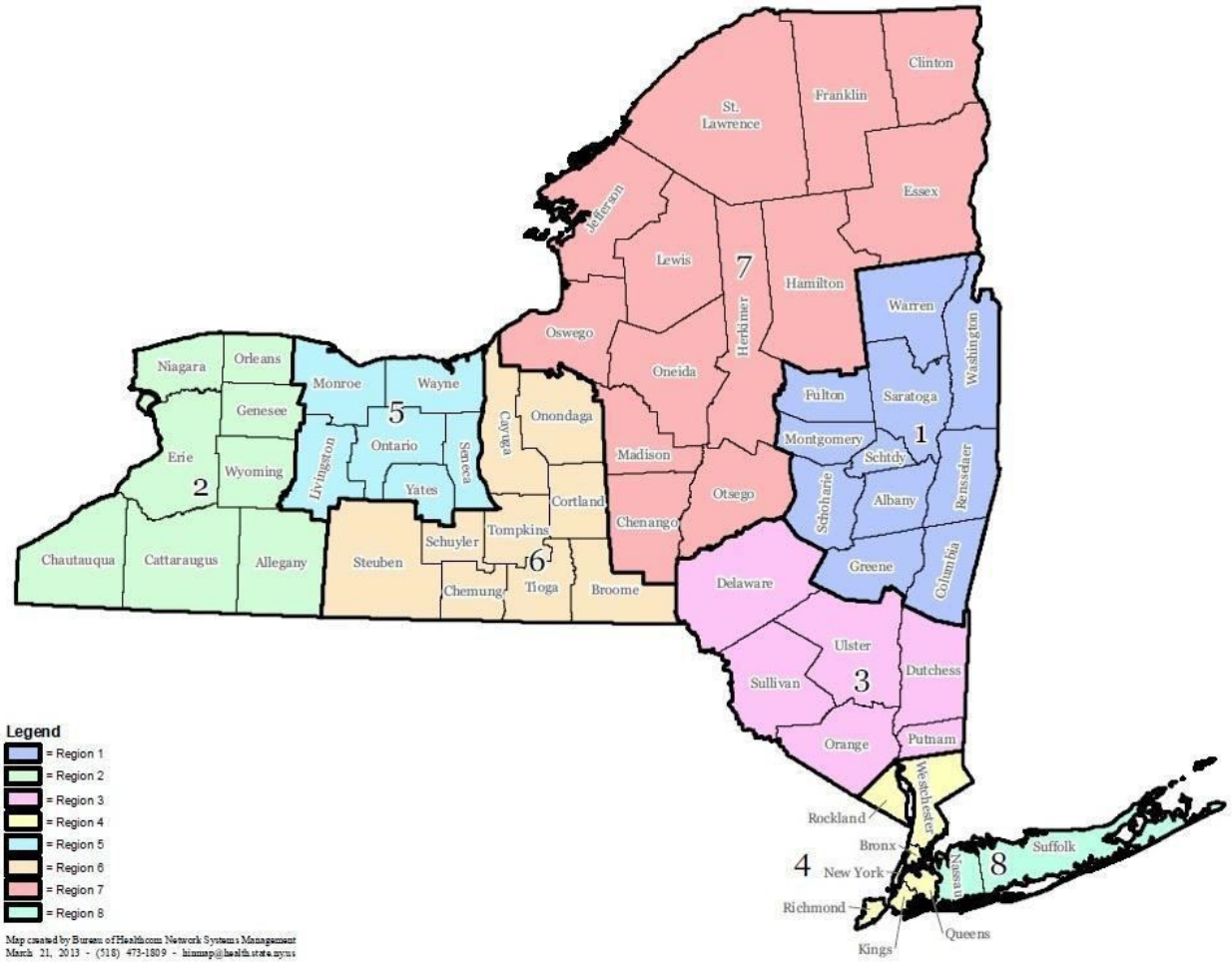
_____

Title

_____

Date

Attachment 2:
New York Standardized Rating Regions



Attachment 3:
Gates and Milestones

Gate 1: Eligibility for the PC practice to receive PT TA from the Contractor and financial support from payers.

Milestone 1 – Participation

- The PC practice has completed and returned the "Practice Self-Assessment Tool" and the PC practice's Clinical and Business lead persons have signed and returned the "APC Practice Participation Attestation," thereby confirming the PC practice's commitment to engage in PT TA services and verifying that they are not receiving duplicative funding.
- The PC practice has created and defined staff roles and assignments to integrate criteria for PT TA services on-site and remotely, and has established proactive engagements with all parties. The PC practice has ensured that roles and task definitions support activities needed to progress toward Milestone completion.
- The PC practice has completed an orientation and attendance sheet provided by the Contractor.

Milestone 2 – Patient-Centered Care

- The PC practice has committed to creating a process for Advanced Directive (AD) discussion with patients.
- The PC practice has developed acceptable protocols/processes for using AD templates for appropriate patients (e.g., older than 65 years) and patients with advanced illness. The template includes discussion of a Health Care Proxy, Living Will and Do Not Resuscitate (DNR) order.
- The PC practice has provided an acceptable narrative description of its process and flagging reminders in a chart or electronic health record (EHR) template.

Milestone 3 – Care Management/Care Coordination

- The PC practice has completed an acceptable self-assessment for behavioral health integration and has committed to, and set goals for, reaching Gate 2 in this area.

Milestone 4 – Access to Care

- The PC practice has committed to providing 24/7 access to patients.
- The PC practice has an on-call schedule that ensures timely telephonic, page and/or secure communication methods with a qualified provider who is accessible 24/7 through a nurse call-line, on-call provider or other PC provider.
- The PC practice has provided an acceptable narrative of their communication workflow.
- The PC practice has created an acceptable one-month report, log or screen shots of their on-call schedule noting response times created by the practice (e.g., 30 minute response time to the patient) and evidence includes patient disposition at the call outcome.

Milestone 5 – Health Information Technology (HIT)

- The PC practice has submitted an acceptable plan for achieving Gate 2, HIT-related Milestones within one (1) year. The plan includes an approach to quality measurement and care coordination tools with steps and associated dates.

Milestone 6 – Payment Model

- The PC practice has committed to value-based payment contracts with APC-participating payers within one (1) year.
- The PC practice has submitted an acceptable summary list of their current payers with contract expiration dates.

Gate 2: Eligibility to receive care coordination payments and a path to early outcome-based payments.

Milestone 1 – Participation

- One (1) PC practice lead or their designee has successfully participated in each of the Contractor's learning activities and has provided attendance records to the Contractor.

Milestone 2 – Patient-Centered Care

- The PC practice has demonstrated commitment to patient engagement activities and has integrated the activities into its work flows within one (1) year.
- The PC practice has submitted an acceptable plan for a patient satisfaction survey, focus group or Patient-Family Advisory Council (PFAC) that includes representation from the PC practice's served populations. The plan includes design of a charter, the survey instrument (if applicable), the patient selection process and staff orientation.
- The PC practice has demonstrated commitment to AD discussion with all patients older than age 65.
- The PC practice uses protocols/processes with the goal of reporting ADs on all patients older than age 65.
- The PC practice has submitted an acceptable narrative description of how it uses protocols/processes to engage and record ADs for eligible patients.
- The PC practice has submitted an acceptable three (3)-month spreadsheet or EHR-generated report that shows the number of patients with an AD in their chart (numerator) and all eligible patients seen in one (1) year (denominator), all declined responses (numerator and denominator) and mechanism for flagging reminders in a paper chart or EHR template.

Milestone 3 – Care Management/Care Coordination

- The PC practice has demonstrated commitment to identify its highest risk patients for care management.
- The PC practice assigns patients to a specific provider care team (small practices may serve as their own care team). Active patients (i.e., last seen within two [2] years) are assigned to a provider.
- The PC practice has implemented a Risk Stratification System for care management using a standardized tool (e.g., American Academy of Family Physicians [AAFP], Agency for Healthcare Research & Quality [AHRQ]) or their own developed process to define and track high-risk patients. The PC practice has generated a consecutive, six (6)-month report with all empaneled patients (numerator) and all active patients (denominator).
- The PC practice has annotated risk scores for easy staff/provider access and identified a care management intervention on at least 1% of its highest-risk patients in the entire panel. The PC practice has named and described its Risk Stratification tool and generated a consecutive, six (6)-month report or spreadsheet that identifies highest-risk patients by risk score.
- The PC practice has demonstrated commitment to planning for care management and/or care coordination delivery within one (1) year.
- The PC practice implements recruitment strategies and/or appropriate training for existing staff regarding care management/care coordination delivery in a practice setting. Care management/care coordination needs are accomplished for at least 2% of the total empaneled population regardless of risk scores and/or highest need patients.
    - The PC practice created job description(s) for care management/care coordination roles that outline practice capacities and define percentage of effort/full-time equivalent (FTE) needs based on the PC practice's high-risk patient population.
    - The PC practice described provision of internal and external training (State-provided care management guidance).

    - The PC practice has submitted acceptable proof of implementation of transitional care management (TCM)/chronic care management (CCM) claims codes they are using.
- The PC practice has demonstrated commitment to integrating an evidence-based process for behavioral health screening, treatment and, where appropriate, referral.
- The PC practice uses PHQ2/PHQ9 for depression screening and a validated screening tool for substance/alcohol abuse, and has demonstrated appropriate screening of eligible adults older than age 18.
- The PC practice engages/participates in and completed an on-line or in-person training for behavioral health integration in PC settings that broadens team-based care and clinical treatment of depression.
- The PC practice has a collaborative care agreement with a behavioral health provider which includes the communication process and description of how patients are seen, treated and tracked. The PC practice has created/implemented a collaborative care agreement that defines tracking and follow up.
- The PC practice has a defined process of adherence to behavioral health quality measures (common score card).
- The PC practice has demonstrated commitment to having a process in place for care plan development.
- The PC practice has identified key components of a structured Care Plan that best fits its patients' needs with goals and preferences. The Plan includes a work flow chart or protocol that includes specific goals for patient engagement.
    - The PC practice has implemented at least three (3) nationally-recognized (e.g., AHRQ) or Contractor-approved Shared Decision-Making Tools with priority given to quality measures in the common measure set (e.g., colonoscopy, antibiotic use, back pain management, weight management, depression).
    - The PC practice has integrated the use of technology for record tracking and secure communication methodology, and educated patients regarding secure communication.
    - The PC practice has established structured Care Plans, including use of a template, tracking tool and criteria used to identify patient needs during Care Management/Care Coordination periods. The PC practice has provided an acceptable baseline EHR report or tracking tool showing the percentage of patients in a high risk category with a Care Plan.
- The PC practice has demonstrated commitment to systematically utilizing a referral tracking system.
- The PC practice has developed the capability for systematically tracking patients throughout referral processes. The PC practice has created clinical/non-clinical staffing workflow patterns to track referrals made, patients seen, consultation reports received and flagging of missing information. The PC practice has demonstrated that staff workflow assignments have been operationalized and have provided screenshots of their EHR referral tracking workflow.

<u>Milestone 4</u> – <u>Access to Care</u>

- The PC practice has demonstrated commitment to improving communication capabilities.
- The PC practice has improved communication capabilities by using secure communication methods or a nurse call-line for other non-urgent care. The PC practice assures navigation to other care coordination and referrals to educational resources (e.g., diabetes education tools, navigation to patient health questionnaires, proper utilization of emergency department vs. office visits).
- The PC practice has provided three (3) de-identified screenshots or examples that show acceptable patient communication for non-urgent care provided after hours through use of secure communication methods or a nurse call-line.
- The PC practice has demonstrated commitment to providing same day appointments.

- The PC practice has reviewed its hours of operation and scheduling patterns to determine the most successful method of ensuring same-day appointment availability. The PC practice has described its policy and process for same day appointments.
- The PC practice has provided an acceptable narrative on its method to assess and meet patient demands, including its policy and workflow assignments for maintaining schedules.
- The PC practice has assessed its demands for same day appointments with a goal to satisfy at least 80% of its patient demand. The PC practice has measured patients seen at same-day appointments (numerator) and patient phone calls requesting same-day appointments (denominator) and improvements in a three (3)-month period.
- The PC practice has demonstrated commitment to providing culturally and linguistically appropriate services.
- The PC practice has assessed the need, and developed an acceptable plan, to address population diversity and cultural needs.
- The PC practice has engaged interpretation services, as applicable to the practice's population needs including vision or hearing impaired.
- The PC practice provides preferred language materials (print and/or electronic) to patients that meet the practice's community needs.
- The PC practice has identified their panels by language and ethnicity for services intervention. The PC practice has provided a screenshot of documentation in EHR or spreadsheet/log. The PC practice has provided an example of printed materials used if the particular population group is greater than 5% of the panel.

Milestone 5 – HIT

- The PC practice has demonstrated commitment to utilizing tools for quality measurement encompassing all core measures and to attesting to connect to HIE within one (1) year.
- The PC practice has the ability to capture, calculate and report all core measures, developed basic Information Exchange and committed to connect to HIE within one (1) year by establishing a participation agreement with their Regional Health Information Organization (RHIO).
- The PC practice has demonstrated certified health information: common clinical data set, demographics, vital signs, body mass index and growth charts and problem list.
- The PC practice has demonstrated clinical quality improvement: capture, calculate and report measures; active medication list; medication allergy list; smoking status; patient list creation; secure messaging; and view, download and transmit to third party.
- The PC practice has signed a RHIO participation agreement.

Milestone 6 – Payment Model

- The PC practice has demonstrated commitment to contracts for minimum fee-for- service (FFS) with Pay for Performance (P4P) contracts with participating payers representing 40% of the panel with commitment to achieving 60%.
- The PC practice has signed contracts meeting the criteria representing 40% of the panel with a commitment to achieve 60%.
- The PC practice has provided a report of the number of patients attributed to each APC-participating payer or other reports that show the reach/impact of the contracts. The PC practice has submitted an acceptable report on its total current empaneled patients.

Gate 3: Eligibility to sustain care coordination payments and evolve to outcome-based payments.

Milestone 1 – Participation

- The PC practice has continued to actively participate in PT TA services.

Milestone 2 – Patient-Centered Care

- The PC practice has implemented patient engagement into its workflows including a Quality Improvement (QI) plan grounded in evidence-based criteria.
- The PC practice implemented and provided evidence of at least one (1) annual patient engagement strategy resulting in the use of at least one (1) QI project that will effect practice change. The PC practice demonstrated its process for incorporating care team staff, patients, families and/or community-based organizations into its strategy efforts (e.g., addressed patient wait times or patient-reported outcomes).
- The PC practice completed a patient survey for at least 8% of its discrete patients at two (2), six (6)-month intervals and provided the results to its patients.
- The PC practice provided an acceptable report of the results and included its survey sample.
- The PC practice provided its area of QI selection and results on a quarterly basis if they used a focus group or PFAC, including sample agendas, meeting minutes and QI strategy results.
- The PC practice demonstrated commitment to sharing ADs across the medical neighborhood where feasible.
- The PC practice demonstrated that its ADs (including eMOLST) are made available in electronic form to share with other health care providers and exchanged through HIE. The PC practice submitted de-identified examples of this communication where feasible.

Milestone 3 – Care Management/Care Coordination

- The PC practice has demonstrated commitment to integrate high risk patient data from other sources (including payers).
- The PC practice has a system in place to actively manage high risk patients and integrate high risk patient data from other sources (including payers). The PC practice manages high risk patients internally or by using a collaborative shared service organization model.
    - The PC practice provided evidence of actively managing high risk patients (e.g., through EHR, spreadsheet for patient panel or improved risk scores).
- The PC practice has demonstrated commitment to delivering care management to its highest risk patients.
- The PC practice has ensured that all high risk patients are offered care management through the PC practice, a contracted entity or other identified specialty practice.
- The PC practice has demonstrated care management/care coordination integrated delivery through introduction of services (potentially acquired through shared service organizations), such as nutritional care, pharmacy and behavioral health specialties.
- The PC practice conducts structured huddles/meetings to discuss cases with the care team.
- The PC practice provides structured outreach/protocols in care transition settings, including "back to home."
- The PC practice engages/conducts trainings for use of payer utilization reports of high risk patients.
    - The PC practice provided an acceptable narrative description of its use of payer utilization reports to identify/compare high risk patients as defined by the PC practice.
- The PC practice provided evidence of three (3) consecutive months of de-identified case management logs or EHR reports regarding continued care and use of TCM/CCM claim codes.
- The PC practice indicated risk score status changes and shared integrated care was delivered with follow up appointments.
- The PC practice demonstrated its ability to stratify data according to diversity (e.g., race, ethnicity).
- The PC practice has demonstrated commitment to delivering coordinated care management for behavioral health.

- The PC practice uses behavioral health care management services using shared care management resources, including health home care managers, and described a connection to behavioral health case management services.
- The PC practice demonstrated use and capability of sharing the care plan with other health care providers in electronic form and tracking patient progress. The PC practice provided screenshots of the process.
- The PC practice care team demonstrated integrated delivery through linkage with regional social services agencies (e.g., support groups) and produced a report detailing the previous three (3) months of interactions.
- The PC practice demonstrated follow up after depression and substance/alcohol abuse screening at regular intervals and referral tracking. The PC practice generated a three (3)- month follow-up report detailing the appropriateness and timeliness of follow up for applicable patients.
- The PC practice has demonstrated commitment to care plan development in concert with patient preferences and goals.
- The PC practice demonstrated that its patients have a care plan, noting patient goals and preferences for management of chronic disease in the patient record. The PC practice submitted documentation of patients with completed care plans in EHRs (patients with care plan as numerator and all empaneled patients as denominator).
- The PC practice showed capability of sharing the care plan with other health care providers in electronic form. The PC practice demonstrated improvement of the percentage of patients with a care plan, including evidence of shared care planning with other providers.
- The PC practice provided an operational process for systematically tracking patients throughout the referral process including behavioral health and substance abuse.
- The PC practice implemented clinical/non-clinical workflow patterns to track referrals sent, patients seen and consultation reports received with flagging of missing information.
    - The PC practice provided a three (3)-month de-identified EHR report or evidence of a referral tracking template used or other documentation of the operational process.
- The PC practice has demonstrated commitment to establishing care compacts or collaborative agreements for timely consultation with medical specialists and institutions.
- The PC practice established written care compacts with at least two (2) high volume specialists inside or outside of the practice ownership entity, or demonstrated a structured process for coordinated care of patients.
    - The PC practice described its communication, arrangements and copy of care compacts, or narrative process that includes expectations of both parties creating a “closed loop” in patient care.
- The PC practice’s care compacts or description of a structured process includes primary/specialty care expectations, access to care, collaborative care management, patient communication needs and provision of patient transition records.
    - The PC practice provided measures of referrals completed as numerator and referrals made as denominator, and demonstrated improvement in a three (3)-month period.
- The PC practice has demonstrated commitment to creating a post discharge follow up process for timely transitions in care.
- The PC practice developed and documented a process to receive timely notifications (e.g., emergency departments, hospitals).
- The PC practice reviews discharge summaries for missing information (e.g., pursues gaps in discharge communication), and demonstrated review and reconciliation of medications of 50% of discharged patients for a three (3)-month period.
- The PC practice demonstrated contact of discharged patients within 72 hours and discharges requiring patient contact. The PC practice schedules and documents follow up within seven (7) days or as applicable. The PC practice provided a report showing improvement over a three (3) month period including all patients where follow up was made as numerator and all known discharges as denominator.

- The PC practice identifies patients who will need internal case management/case coordination or who will require coordination of care from other health or community-based services. The PC practice provided examples of at least two (2) de-identified patients with TCM/CCM coding utilization shown during a six (6) month period.

Milestone 4 – Access to Care

- The PC practice has demonstrated commitment to providing at least one (1) session weekly during non-traditional hours.
- The PC practice provides a minimum of one (1) non-traditional weekly session of scheduled services defined as before 8:00 a.m. or after 6:00 p.m., and/or weekends. The PC practice provided the ratio of patients seen in non-traditional session(s) to patients seen during normal business hours in a six (6) month period, and provided a narrative of how improvement was achieved.
- The PC practice reviewed hours of operations and scheduling patterns to determine the most successful course in optimization of one (1) non-traditional weekly session. The PC provided a narrative describing its selection of visit types (e.g., 15-minute risk calls, annual physicals, post-discharge follow ups) and time slot templates for the session.

Milestone 5 – HIT

- The PC practice demonstrated commitment to utilizing tools for quality measurement encompassing all core measures and securing electronic provider-patient secure messaging.
- The PC practice is able to provide 24/7 remote access through HIT, including secure electronic provider/patient messaging; information exchange including reconciliation and incorporation of exchanged information using EHR technology certified to 170.314(b) (4); enhanced quality improvement including Clinical Decision Support (CDS); certified HIT for quality improvement and information exchange; and connection to the local Regional Health Information Organization (RHIO).
    - The PC practice provided verification of transitions of care for receiving, displaying and incorporating transition of care/referral summaries including sharing Advanced Directives.
    - The PC practice provided verification of clinical information and medication reconciliation, incorporating lab values and test results; recording immunizations and transmitting to the immunization registry; and clinical decision support interventions that have been enabled.
    - The PC practice provided a transmission report or letter from the RHIO that shows certification of connection.

Milestone 6 – Payment Model

- The PC practice has demonstrated commitment to value-based gain sharing contracts with APC-participating payers representing 60% of the panel.
- The PC practice has signed contracts meeting the criteria of representing 60% of the panel.
    - The PC practice provided a report of patients attributed to Advanced Primary Care (APC) participating payers as numerator and total patients attributed to the practice as denominator.
    - The PC practice provided a report of the number of patients attributed to each APC-participating payer.
    - The PC practice provided a report on the total current empaneled patients.

Milestone 7 – Population Health

- The PC practice has demonstrated commitment to participating in Prevention Agenda activities.
- The PC practice participated in local county health collaborative, Prevention Agenda meetings and participated in at least two (2) activities with Prevention Agenda partners on shared priority

efforts (e.g., integrating pre-conception care, efforts to promote behavioral health well-being). The PC practice discussed shared goals/priorities with its local health department.

- The PC practice demonstrated commitment to identification and outreach to patients due for preventive and chronic care management.
- The PC practice documented clinical decision support interventions that have enabled staff workflows, its process for identifying patients due for preventive and chronic care visits (e.g., preventive screenings) and its use of clinical guidelines for chronic care conditions, including methods of follow up used. The PC practice provided evidence of how its preventive measures (screening) are being tracked.
- The PC practice demonstrated commitment to creating a process to refer to structured health education programs and community based resources.
- The PC practice provided evidence for how it provides and tracks referrals to community-based organizations; and its resources for patients with chronic conditions, social and behavioral health needs (e.g., screenshots of logs or EHR showing referral tracking).

<u>Note</u>: In conjunction with the Contractor, HRI/NYSDOH will provide the PC practice with information on structured health education programs and other resources including local health departments, the local Office for the Aging, the Performing Provider Systems (PPS) community resource compendium and the Population Health Improvement Program (PHIP).

Attachment 4:
Sample Curriculum

Sample Curriculum		
Required modules	**Sample units**	**Sample Topics**
Introduction to APC	*Goals and structure of APC*	Capabilities, milestones and measures
		Business case for outcomes-based payments
		Support provided by APC program during transition
		Practice-specific milestone completion plan incorporating defined timelines and "best practice" strategies
		Developing practice leadership to champion transformation process
HIT	*Integrating HIT into practice workflows*	Creating actionable data: how to integrate population health and other HIT tools into your practice
		Connecting to and using data and services from a RHIO
		Incorporating clinical workflow changes to increase data quality and usage
		Increasing EHR data quality through the use of tools to ensure data can be used for quality reporting and analytics.
		Advanced EHR use for population health, care management and coordination, data measurement and reporting, and other applications
Practice capability building	*Patient-centered care*	Developing a strong practice team and role-based workflows Tools and systems for engaging with patients: motivational interviewing, shared decision-making and more
		Incorporating patient preferences and goals into care and responding to patient's non-medical needs (including cultural competence, vulnerable populations and patient literacy considerations)
		Creating a QI plan based on patient input: patient family advisory councils and patient experience data

	Population Health	Delivering clinical prevention services, including those that help achieve Prevention Agenda goals
		Identifying and supporting activities of the local county Prevention Agenda coalition
		Panel Management: creating structured panels assigned to individual providers and identifying risk-valued categories for EHR tracking
		Evidence-based processes for managing behavioral health that include collaborative care transitions
		Strengthening community linkages and partnerships to: ■ improve delivery of clinical services ■ increase the use of effective community interventions, such as chronic disease self-management programs and National Diabetes Prevention Programs ■ connect patients to resources and supports that can help maintain health
	Access to care	Increasing access to your practice by phone, internet and in person (e.g., by evaluating staffing models, hours of operation and scheduling patterns)
		Serving a culturally and linguistically diverse population and addressing social determinants
	Care coordination and management	Create structured risk stratification and empanelment through use of standardized risk tools
		Medical neighborhoods: care compacts, closed loop referrals and managing patient transitions
		Creating role-based workflows to maximize capabilities of the care team
		Managing your highest-risk patients
		Comprehensive Care Plan development that includes protocols for high risk patients, staff coordination and transitions in care
Performance in outcome-based payments	*Moving from milestones to sustainable outcomes-based payment*	Performance management techniques for measuring, reporting and improving on data: • Plan, Do, Study, Act (PDSA) cycles • Creating a quality improvement plan
		Budgeting for financial success in outcomes-based payment models
		Developing a long-term strategy for care team development: training, job descriptions and role-based workflows
		Workflow optimization: pre-visit planning, team huddles and other strategies

Attachment 5:
Budget Instructions

NYS intends to award a maximum of $20,000,000 in 2017, to fund PT TA Services in up to eight regions throughout the State. In some regions, there will be more than one award. HRI funding for this program will be limited by the terms of the HRI/NYSDOH SIM award received each year.

A PC practice site is defined as the unique physical location, along with a roster of affiliated PC physicians.

Applicants must use this attachment to indicate and detail the proposed dollar amounts for both the Monthly/Recurring Payments and the Non-Recurring Payments, described below. These are the only payments that contractors will receive from HRI/NYSDOH. Payments should be inclusive of all costs associated with the contract.

Recurring Payments:

Applicants may propose a monthly payment of up to $1,200 for the provision of PT TA services to an enrolled PC practice. The Contractor may bill for an enrolled PC practice if the PC practice was enrolled on Day 15 of the billable month. If a PC practice fails to pass Gate 2 or 3 within 12 months, the Contractor is not eligible for a monthly payment until the PC practice passes the Gate.

The applicant should also complete the "Number of Proposed Practice Sites" space at the bottom of the "Recurring Payment Matrix" to indicate the number of practices it proposes to provide with PT TA services.

Non-recurring Payments:

Applicants may propose a non-recurring payment of up to $1,000. For PC practices receiving PT TA services under this Contract, the Contractor is eligible for a one-time payment at the proposed rate when a PC practice completes all of the Gate 2 Milestones and a one-time payment at this rate when a PC practice completes all of the Gate 3 Milestones, for a maximum of two (2) payments per PC practice.

For PC practices not receiving PT TA services under this Contract, the Contractor is eligible for a one-time payment at this rate when completing and providing a Gate assessment to a PC practice that does not request PT TA services or is ineligible for PT TA services under this Contract.

Cost Matrix:

Applicants should complete the two tables that follow to propose unit and practice costs.

All fields in the two tables should be completed, including references to the narrative where necessary. Describe the proposed units for each modality of service (e.g., 60 minutes of onsite coaching with the practice manager, one 30-minute webinar with Q&A functionality) for the "standard" curriculum. For each modality, describe the average number of units of support provided in the curriculum for a typical practice and the average cost per unit. Assume the same cost per participating practice site, on average, regardless of starting point (i.e., "Gate 1" or "Gate 2"). HRI/NYSDOH reserves the right to enter into negotiations with selected awardees that may modify this budget, including scaling up or down the intensity of support in proportion with changes in the budget. Costs per unit should be inclusive of all costs. Descriptions of each of these modalities are provided in Section III.

Recurring Payments Matrix – 15 Points

Modality of service	Description of unit	# units per practice site per month	Cost per unit	Cost per practice site per Month
Example *In person coaching*	*60 minutes of on-site coaching with appropriate PC practice staff*	*2*	*$100*	*$200*
Reporting requirements				
In person coaching				
Learning collaborative				
Group trainings				
Remote support (webinars)				
Remote support (phone and/or email)				
Other (append description)				
Total cost per practice site, per month				$
Number of Proposed Practice sites				

Non-recurring Payment Matrix - 5 points

Modality of service	Description of Service	# units per practice assessment	Cost per unit	Cost per practice Assessment
On-site Data Collection				
Desk Review				
Analysis of Milestones				
Total Non-recurring Payment amount				$

Attachment 6:
Practice Transformation Technical Assistance Services Contract
Practice Self-Assessment Tool

Practice Self-Assessment Tool
Practice Transformation Technical Assistance Services

Provided by: _____
(Practice Transformation Technical Assistance Organization)

Who should complete this tool?
If you are a primary care (PC) practice with an independent business operating model that currently does not receive federal and/or New York State (NYS) funding for Practice Transformation (PT) through direct support (i.e., Delivery System Reform Incentive Payment [DSRIP] Program, Medicare Shared Savings Program [MSSP], Multi-Payer Advanced Primary Care Practice [MAPCP], Comprehensive Primary Care [CPC] Initiative), your PC practice could be eligible for up to two (2) years of PT Technical Assistance (TA) services. Even if your practice already participates in another PT program, you may still be eligible for PT services and should still complete the tool.

Why?
The above organization has been funded through a Centers for Medicare & Medicaid Services (CMS) grant to provide TA services to PC practices for transformation to Advanced Primary Care (APC). The APC model is designed to help PC practices evolve to assure readiness to participate in value-based payment (VBP) models being developed and implemented by both public and private payers. More information regarding APC can be found on CMS's website: https://innovation.cms.gov/initiatives/Advanced-Primary-Care/

How will completing the "Practice Self-Assessment Tool" help?
The tool will help provide a way for your team to see how your practice is currently structured. Your completed tool will also help the above organization to provide you with PT TA services consistent with the APC model and the future of VBP models. Your candid and thoughtful responses will make a big difference in providing a baseline to target opportunities for PT TA.

How long will it take to complete the tool?
To be mindful of your time, we estimate that completion will take less than 20 minutes.

Who should complete the tool?
Preferably, a provider lead at your practice should complete the tool. However, most questions can easily be answered by a practice/site manager in collaboration with the provider lead.

Practice Self-Assessment Tool

Business Name of Practice: _____

Location of Primary Site: _____

_____

Phone Number: _____

Name of Lead Physician: _____

Practice Manager/Contact Person:_____

Contact Person Phone Number: _____

Contact Person Email: _____

Locations of Secondary Sites: _____

_____

_____

_____

1. Please check the program(s) below that your PC practice currently participates in:

Program	√
Delivery System Reform Incentive Payment (DSRIP) Program, Performing Provider System (PPS)	
Transforming Clinical Practice Initiative (TCPI), New York State Practice Transformation Network (NYSPTN)	
Transforming Clinical Practice Initiative (TCPI), New York University Practice Transformation Network (NYU PTN) (Brooklyn)	
Transforming Clinical Practice Initiative (TCPI), National Council for Behavioral Health	
Comprehensive Primary Care (CPC) Plus	
Medicare Shared Savings Program, Pioneer Accountable Care Organization (ACO)	
Multi-Payer Advanced Primary Care (MAP-CP) Program	
Center for Medicare and Medicaid Innovation (CMMI): Health Care Innovation Award (HCIA) Project	

2. Which categories below best describe your practice (check all that apply)?

Category	√
Solo practice	
Small group (1-5 primary care providers)	
Larger group (6-25 primary care providers)	
Single specialty primary care	
Multi-specialty primary care	
Group or staff HMO/MCO	
Federally Qualified Health Center (FQHC) or Community Health Center	
Hospital or hospital-based system	
Integrated health system	
Other (specify):	

3. Which organizational affiliations does your practice have (check all that apply)?

Organization	√
Independent Practice Association	
Another physician practice association	
Physician Hospital Organization	
Integrated Health System	
Accountable Care Organization (please list all):	
Other (specify):	

4. Answer the questions below to the best of your ability regarding your practice composition and business operations:

Question	Yes	No
Beyond insurance payments, does your practice charge a "retainer" or "concierge" fee for some or all of your patients?		
Does an entity other than your practice employ the non-clinical staff in your practice (i.e., hospital, university, physician practice organization)?		
Are your patients able to schedule appointments directly with your practice?		
Does your practice anticipate any potential change in ownership and/or composition over the next 12 months?		
Is your practice in the process of achieving, or have you achieved, National Committee for Quality Assurance (NCQA), Patient-Centered Medical Home (PCMH) recognition at Level III under 2014 Standards?		

5. What percentage of your practice's total revenue in the last 12 months came from the following (total should equal 100%)?

Reimbursement	Percent
Fee-for-service	
Capitation or fixed payment	
Care management fees	
Shared savings and/or quality-based payments	
Other payments (please describe):	
Total	**100%**

6. Other than payer reimbursements, is your practice incentivized through Relative Value Units (RVUs), panel size, non-visit based work or another incentive type?

_____ Yes _____ No

7. If applicable, does your practice use and report quality measures in calculating incentives?

_____ Yes _____ No

8. Please provide an estimate of the total number of unique patients seen in your practice regardless of payment:

_____

9. Please provide the number of persons working at your practice site by job title, length of employment, full/part time and shared employees (e.g., "pod" arrangement):

Title	Number Employed	Number Employed More than 1 Year	Number Full Time	Number Shared
Primary Care Physician				
Physician Assistant				
Nurse Practitioner				
Registered Nurse (clinical setting only)				
Licensed Practical Nurse				
Licensed Vocational Nurse				
Medical Assistant				
Case Manager/Coordinator				
Practice Manager				
Administrative				
Community Service/Navigator				
Behavioral Health Specialist				
Disease-based (e.g., Nutritionist)				
Pharmacy Specialist				
Total				

10. On a scale of 1-5, using the following key, please indicate below the degree to which your practice has accomplished each of the items below:

1 = Is not done.
2 = Is done, but not routinely.
3 = Is done routinely in some situations.
4 = Is done routinely in most situations.
5 = Is always done.

Patient-Centered Care:	1	2	3	4	5
Assessing patient and family values and preferences is systematically done by providers and staff with formalized documentation in care planning.					
Systematic assessment of patient needs and goals is done consistently for all patients so that services match their needs.					
Process for discussion of Advanced Directives with patients is fully in place and incorporated into electronic health record care plans and used for care transitions.					
Process for ensuring patient/family communication is systematically assessed and staff are trained in health literacy and communication techniques for integration of patient planning.					
Referral relationships and tracking patient care transitions is in place and referral partners consistently exchange relevant data, often in advance of visits, with timely, trackable patient follow-up and/or sharing of same electronic health records.					
Patient engagement and feedback is collected through routine surveys, focus groups or Patient Family Advisory Council (PFAC), measurable data are used to guide improvements and results are shared with patients and/or external entities.					
Linking patients to community-based support and resources is done and a practice team has protocols and workflows in place with communication between the practice, community-based entities, patients and electronic health records.					
Medication reconciliation and patient notification of lab and imaging results is done with medication reconciliation reports consistently used for quality assurance and patient notifications are tracked through reporting tools.					

Care Management/Care Coordination:	1	2	3	4	5
Evidence-based guidelines on care prevention and treatment of chronic illness are used with consistent protocols guiding and creating patient-level reports for care teams to use prior to visits and at point-of-service.					
Standard methods or tools are used in risk stratification of patients, such as the American Academy of Family Practice, and integrated care and risk stratification of highest risk patients are optimally recorded and reports are generated in electronic health records for quality improvement of outcomes.					
Care plans are fully developed, integrated and documented in					

Care Management/Care Coordination:	1	2	3	4	5
electronic health records, and include specialty referrals, medication updates, preventive care screening and discharges.					
Shared decision-making and self-support management is consistently provided both for many conditions and preventive care, and goals are documented in electronic health records and evaluated at point-of-care.					
Practice follow up with patients seen in emergency departments, hospitals and length of stay facilities is done with daily protocols and tracking in electronic health records for use by the care team to optimize care coordination across health care settings. Case managers code for transitions of care/chronic care management (TCM/CCM).					
Care team management services for high risk patients have a fully integrated, developed care management service through an imbedded, contracted or shared care manager on a full-time or part-time basis as needed by the patient population.					
Behavioral health integration and care coordination processes, tools, screening and treatment, including depression, is consistently performed and referral partners routinely exchange pertinent information to optimize patient care.					

Access and Continuity of Care:	1	2	3	4	5
Patient empanelment is done with a goal of the care team having a system in place to review scheduling patterns for clinical need and reports status.					
24/7 patient access to care is available with a covering provider, nurse line or care team staff having real time access to electronic health records and patients have a choice in communication such as phone or email at all times.					
Asynchronous communication with patients includes routine scheduled phone visits, group visits or telehealth.					
An appointment system is in place and it can generate reports for use in scheduling management and to guide quality improvement.					

Population Health and Quality Measurement:	1	2	3	4	5
Performance measures and internal quality reporting is in place with tracking and reporting on several chronic and preventive measures with use of data for quality improvement. There is also a system for prevention outreach. Data can be transparently reported to patients or external sources.					
External cost and utilization data are used with payer data consistently used to drive lower costs and utilization in such areas as avoidable readmissions and emergency department use, testing and diagnostics.					
Quality improvement activities are conducted based on continuous, sustainable improvement strategies that meaningfully engage all					

Population Health and Quality Measurement:	1	2	3	4	5
members of the care team, as well as patients and families.					

Health Information Technology:	1	2	3	4	5
Electronic health records are used including certified electronic health record technology (CEHRT) and upgrades and capacities are incorporated through a vendor.					
Data management capabilities for panel-level data, registries, health information exchange and Regional Health Information Organizations (RHIOs) are used for pre-visit planning and outreach, and are also engaged for building relationships and capacities for interoperability among medical neighborhoods.					
Meaningful Use (MU) 2 has been met and operational redesign functionality use has been optimized to eliminate health care waste and decrease costs.					

Business Model Development:	1	2	3	4	5
Practice development and business acumen for various types of alternative payment models for public and/or commercial payers is in place with a capable business management team, resources and current participation in alternative payment models with a focus on sustainability in a value-based environment.					

Completed by:

Name: _____

Title: _____

Date: _____

Phone Number: _____

Email: _____

Attachment 7:
Practice Transformation Technical Assistance Services Contract
APC Practice Participation Attestation

Following completion of the Practice Self-Assessment Tool and interest has been expressed by the PC practice to receive Practice Transformation Technical Assistance (PT TA) services, the Contractor will request that each PC practice site completes the Advanced Primary Care (APC) Practice Participation Attestation, which will serve as a binding document for enrollment in the APC model. The Contractor will ask the PC practice to have the Attestation signed by the Clinical lead person and Business lead person, notarized and returned to Contractor.

The Attestation will serve as the on-boarding document to enable the PC practice to receive PT TA services from the Contractor and/or begin the Gate/Milestone process.

APC Practice Participation Attestation

Provided by: _____
(Practice Transformation Technical Assistance Organization)

_____
(Name of Primary Care Practice)

_____
(Street Address, Suite, Building, etc.)

_____, New York _____
(City/Town) (Zip Code)

The practice named above agrees to actively, consistently and progressively participate in Advanced Primary Care (APC) Practice Transformation Technical Assistance (PT TA) services provided by the above named PT TA organization. I understand that these services are designed to allow my practice to accomplish goals/activities to enable value-based payment arrangements with participating payers.

The above PT TA organization will lead my practice through three (3) APC-specific "Gates" with associated Milestones (Attachment A). I understand that my practice must fulfill all of the Milestones in the Gate in order to be eligible to move to the next Gate. The PT TA organization will provide PT TA services to my practice for up to two (2) years, depending on the initial readiness of my practice, in building capabilities for my practice to reach the APC goals and to progress through the three (3) Gates.

My practice agrees to provide a Clinical lead person who will be responsible for overall accomplishments of the PT process, and a Business lead person who will serve as Liaison to the PT TA organization regarding all APC information, PT activities and to meet Gate/Milestone requirements on behalf of the practice.

My practice and its staff agrees to comply with all applicable laws and regulations related to disclosure of personally-identifiable information and other confidential information including but not limited to reporting required by APC Gates/Milestones accomplishments.

My practice agrees to comply with all monitoring and evaluation requirements, including but not limited to an Independent Validation Agent (IVA) that will have oversight of APC Gates/Milestones over the course of the statewide PT TA project. Examples include provision of additional information and compliance with requests for interviews.

My practice understands that information requested from payers will be provided by the IVA, Health Research, Inc. or the New York State Department of Health. This information relates to Gate validation and practice readiness and will be provided, upon request, for payer care management fees and/or value-based payment arrangements.
My practice understands the PT TA organization may deny or terminate services if they find my practice to be in receipt of more than one federal funding source for PT activities during the same time frame. My practice understands that the PT TA organization may deny or terminate services if they find my practice to be non-compliant, or may specify corrective action requirements in order for my practice to continue participating in PT TA services. If the PT TA organization determines that my practice has committed illegal or inappropriate activity, or any issues that may not be in the best interest of the APC model, they will terminate services and report their findings to the New York State Department of Health.

My practice understands that, upon signature, notarization and receipt of this Attestation, pertinent

enrollment information will be provided to an electronic statewide database that will allow oversight by the IVA, Health Research, Inc. and New York State Department of Health.

Clinical Lead Person:

_____

Name

_____

Title

_____

Signature

_____

Date

STATE OF NEW YORK)
) SS:
County of _____)

On the ___ day of _____ in the year _____ before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is(are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their/ capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

_____

(Signature and office of the individual taking acknowledgement)

Business Lead Person:

_____

Name

_____

Title

_____

Signature

_____

Date

STATE OF NEW YORK)
) SS:
County of _____)

On the ___ day of _____ in the year _____ before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is(are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their/ capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

_____

(Signature and office of the individual taking acknowledgement

Attachment A
APC Gates and Milestones

Gate 1: Eligibility for the primary care (PC) practice to receive Practice Transformation Technical Assistance (PT TA) from the PT TA Organization and financial support from payers.

Milestone 1 – Participation

- The PC practice has completed and returned the "Practice Self-Assessment Tool" and the PC practice's Clinical and Business lead persons have signed and returned the "APC Practice Participation Attestation," thereby confirming the PC practice's commitment to engage in PT TA services and verifying that they are not receiving duplicative funding.
- The PC practice has created and defined staff roles and assignments to integrate criteria for PT TA services on-site and remotely, and has established proactive engagements with all parties. The PC practice has ensured that roles and task definitions support activities needed to progress toward Milestone completion.
- The PC practice has completed an orientation and attendance sheet provided by the PT TA Organization.

Milestone 2 – Patient-Centered Care

- The PC practice has committed to creating a process for Advanced Directive (AD) discussion with patients.
- The PC practice has developed acceptable protocols/processes for using AD templates for appropriate patients (e.g., older than 65 years) and patients with advanced illness. The template includes discussion of a Health Care Proxy, Living Will and Do Not Resuscitate (DNR) order.
- The PC practice has provided an acceptable narrative description of its process and flagging reminders in a chart or electronic health record (EHR) template.

Milestone 3 – Care Management/Care Coordination

- The PC practice has completed an acceptable self-assessment for behavioral health integration and has committed to, and set goals for, reaching Gate 2 in this area.

Milestone 4 – Access to Care

- The PC practice has committed to providing 24/7 access to patients.
- The PC practice has an on-call schedule that ensures timely telephonic, page and/or secure communication methods with a qualified provider who is accessible 24/7 through a nurse call-line, on-call provider or other PC provider.
- The PC practice has provided an acceptable narrative of their communication workflow.
- The PC practice has created an acceptable one-month report, log or screen shots of their on-call schedule noting response times created by the practice (e.g., 30 minute response time to the patient) and evidence includes patient disposition at the call outcome.

Milestone 5 – Health Information Technology (HIT)

- The PC practice has submitted an acceptable plan for achieving Gate 2, HIT-related Milestones within one (1) year. The plan includes an approach to quality measurement and care coordination tools with steps and associated dates.

Milestone 6 – Payment Model

- The PC practice has committed to value-based payment contracts with APC-participating payers within one (1) year.

- The PC practice has submitted an acceptable summary list of their current payers with contract expiration dates.

Gate 2: Eligibility to receive care coordination payments and a path to early outcome-based payments.

Milestone 1 – Participation

- One (1) PC practice lead or their designee has successfully participated in each of the PT TA Organization's learning activities and has provided attendance records to the PT TA Organization.

Milestone 2 – Patient-Centered Care

- The PC practice has demonstrated commitment to patient engagement activities and has integrated the activities into its work flows within one (1) year.
- The PC practice has submitted an acceptable plan for a patient satisfaction survey, focus group or Patient-Family Advisory Council (PFAC) that includes representation from the PC practice's served populations. The plan includes design of a charter, the survey instrument (if applicable), the patient selection process and staff orientation.
- The PC practice has demonstrated commitment to AD discussion with all patients older than age 65.
- The PC practice uses protocols/processes with the goal of reporting ADs on all patients older than age 65.
- The PC practice has submitted an acceptable narrative description of how it uses protocols/processes to engage and record ADs for eligible patients.
- The PC practice has submitted an acceptable three (3)-month spreadsheet or EHR-generated report that shows the number of patients with an AD in their chart (numerator) and all eligible patients seen in one (1) year (denominator), all declined responses (numerator and denominator) and mechanism for flagging reminders in a paper chart or EHR template.

Milestone 3 – Care Management/Care Coordination

- The PC practice has demonstrated commitment to identify its highest risk patients for care management.
- The PC practice assigns patients to a specific provider care team (small practices may serve as their own care team). Active patients (i.e., last seen within two [2] years) are assigned to a provider.
- The PC practice has implemented a Risk Stratification System for care management using a standardized tool (e.g., American Academy of Family Physicians [AAFP], Agency for Healthcare Research & Quality [AHRQ]) or their own developed process to define and track high-risk patients. The PC practice has generated a consecutive, six (6)-month report with all empaneled patients (numerator) and all active patients (denominator).
- The PC practice has annotated risk scores for easy staff/provider access and identified a care management intervention on at least 1% of its highest-risk patients in the entire panel. The PC practice has named and described its Risk Stratification tool and generated a consecutive, six (6)-month report or spreadsheet that identifies highest-risk patients by risk score.
- The PC practice has demonstrated commitment to planning for care management and/or care coordination delivery within one (1) year.
- The PC practice implements recruitment strategies and/or appropriate training for existing staff regarding care management/care coordination delivery in a practice setting. Care management/care coordination needs are accomplished for at least 2% of the total empaneled population regardless of risk scores and/or highest need patients.

    - The PC practice created job description(s) for care management/care coordination roles that outline practice capacities and define percentage of effort/full-time equivalent (FTE) needs based on the PC practice's high-risk patient population.
    - The PC practice described provision of internal and external training (State-provided care management guidance).
    - The PC practice has submitted acceptable proof of implementation of transitional care management (TCM)/chronic care management (CCM) claims codes they are using.
- The PC practice has demonstrated commitment to integrating an evidence-based process for behavioral health screening, treatment and, where appropriate, referral.
- The PC practice uses PHQ2/PHQ9 for depression screening and a validated screening tool for substance/alcohol abuse, and has demonstrated appropriate screening of eligible adults older than age 18.
- The PC practice engages/participates in and completed an on-line or in-person training for behavioral health integration in PC settings that broadens team-based care and clinical treatment of depression.
- The PC practice has a collaborative care agreement with a behavioral health provider which includes the communication process and description of how patients are seen, treated and tracked. The PC practice has created/implemented a collaborative care agreement that defines tracking and follow up.
- The PC practice has a defined process of adherence to behavioral health quality measures (common score card).
- The PC practice has demonstrated commitment to having a process in place for care plan development.
- The PC practice has identified key components of a structured Care Plan that best fits its patients' needs with goals and preferences. The Plan includes a work flow chart or protocol that includes specific goals for patient engagement.
    - The PC practice has implemented at least three (3) nationally-recognized (e.g., AHRQ) or PT TA Organization-approved Shared Decision-Making Tools with priority given to quality measures in the common measure set (e.g., colonoscopy, antibiotic use, back pain management, weight management, depression).
    - The PC practice has integrated the use of technology for record tracking and secure communication methodology, and educated patients regarding secure communication.
    - The PC practice has established structured Care Plans, including use of a template, tracking tool and criteria used to identify patient needs during Care Management/Care Coordination periods. The PC practice has provided an acceptable baseline EHR report or tracking tool showing the percentage of patients in a high risk category with a Care Plan.
- The PC practice has demonstrated commitment to systematically utilizing a referral tracking system.
- The PC practice has developed the capability for systematically tracking patients throughout referral processes. The PC practice has created clinical/non-clinical staffing workflow patterns to track referrals made, patients seen, consultation reports received and flagging of missing information. The PC practice has demonstrated that staff workflow assignments have been operationalized and have provided screenshots of their EHR referral tracking workflow.

<u>Milestone 4</u> – <u>Access to Care</u>

- The PC practice has demonstrated commitment to improving communication capabilities.
- The PC practice has improved communication capabilities by using secure communication methods or a nurse call-line for other non-urgent care. The PC practice assures navigation to other care coordination and referrals to educational resources (e.g., diabetes education tools, navigation to patient health questionnaires, proper utilization of emergency department vs. office visits).

- The PC practice has provided three (3) de-identified screenshots or examples that show acceptable patient communication for non-urgent care provided after hours through use of secure communication methods or a nurse call-line.
- The PC practice has demonstrated commitment to providing same day appointments.
- The PC practice has reviewed its hours of operation and scheduling patterns to determine the most successful method of ensuring same-day appointment availability. The PC practice has described its policy and process for same day appointments.
- The PC practice has provided an acceptable narrative on its method to assess and meet patient demands, including its policy and workflow assignments for maintaining schedules.
- The PC practice has assessed its demands for same day appointments with a goal to satisfy at least 80% of its patient demand. The PC practice has measured patients seen at same-day appointments (numerator) and patient phone calls requesting same-day appointments (denominator) and improvements in a three (3)-month period.
- The PC practice has demonstrated commitment to providing culturally and linguistically appropriate services.
- The PC practice has assessed the need, and developed an acceptable plan, to address population diversity and cultural needs.
- The PC practice has engaged interpretation services, as applicable to the practice's population needs including vision or hearing impaired.
- The PC practice provides preferred language materials (print and/or electronic) to patients that meet the practice's community needs.
- The PC practice has identified their panels by language and ethnicity for services intervention. The PC practice has provided a screenshot of documentation in EHR or spreadsheet/log. The PC practice has provided an example of printed materials used if the particular population group is greater than 5% of the panel.

Milestone 5 – HIT

- The PC practice has demonstrated commitment to utilizing tools for quality measurement encompassing all core measures and to attesting to connect to HIE within one (1) year.
- The PC practice has the ability to capture, calculate and report all core measures, developed basic Information Exchange and committed to connect to HIE within one (1) year by establishing a participation agreement with their Regional Health Information Organization (RHIO).
- The PC practice has demonstrated certified health information: common clinical data set, demographics, vital signs, body mass index and growth charts and problem list.
- The PC practice has demonstrated clinical quality improvement: capture, calculate and report measures; active medication list; medication allergy list; smoking status; patient list creation; secure messaging; and view, download and transmit to third party.
- The PC practice has signed a RHIO participation agreement.

Milestone 6 – Payment Model

- The PC practice has demonstrated commitment to contracts for minimum fee-for- service (FFS) with Pay for Performance (P4P) contracts with participating payers representing 40% of the panel with commitment to achieving 60%.
- The PC practice has signed contracts meeting the criteria representing 40% of the panel with a commitment to achieve 60%.
- The PC practice has provided a report of the number of patients attributed to each APC-participating payer or other reports that show the reach/impact of the contracts. The PC practice has submitted an acceptable report on its total current empaneled patients.

Gate 3: Eligibility to sustain care coordination payments and evolve to outcome-based payments.

Milestone 1 – Participation

- The PC practice has continued to actively participate in PT TA services.

Milestone 2 – Patient-Centered Care

- The PC practice has implemented patient engagement into its workflows including a Quality Improvement (QI) plan grounded in evidence-based criteria.
- The PC practice implemented and provided evidence of at least one (1) annual patient engagement strategy resulting in the use of at least one (1) QI project that will effect practice change. The PC practice demonstrated its process for incorporating care team staff, patients, families and/or community-based organizations into its strategy efforts (e.g., addressed patient wait times or patient-reported outcomes).
- The PC practice completed a patient survey for at least 8% of its discrete patients at two (2), six (6)-month intervals and provided the results to its patients.
- The PC practice provided an acceptable report of the results and included its survey sample.
- The PC practice provided its area of QI selection and results on a quarterly basis if they used a focus group or PFAC, including sample agendas, meeting minutes and QI strategy results.
- The PC practice demonstrated commitment to sharing ADs across the medical neighborhood where feasible.
- The PC practice demonstrated that its ADs (including eMOLST) are made available in electronic form to share with other health care providers and exchanged through HIE. The PC practice submitted de-identified examples of this communication where feasible.

Milestone 3 – Care Management/Care Coordination

- The PC practice has demonstrated commitment to integrate high risk patient data from other sources (including payers).
- The PC practice has a system in place to actively manage high risk patients and integrate high risk patient data from other sources (including payers). The PC practice manages high risk patients internally or by using a collaborative shared service organization model.
    - The PC practice provided evidence of actively managing high risk patients (e.g., through EHR, spreadsheet for patient panel or improved risk scores).
- The PC practice has demonstrated commitment to delivering care management to its highest risk patients.
- The PC practice has ensured that all high risk patients are offered care management through the PC practice, a contracted entity or other identified specialty practice.
- The PC practice has demonstrated care management/care coordination integrated delivery through introduction of services (potentially acquired through shared service organizations), such as nutritional care, pharmacy and behavioral health specialties.
- The PC practice conducts structured huddles/meetings to discuss cases with the care team.
- The PC practice provides structured outreach/protocols in care transition settings, including "back to home."
- The PC practice engages/conducts trainings for use of payer utilization reports of high risk patients.
    - The PC practice provided an acceptable narrative description of its use of payer utilization reports to identify/compare high risk patients as defined by the PC practice.
- The PC practice provided evidence of three (3) consecutive months of de-identified case management logs or EHR reports regarding continued care and use of TCM/CCM claim codes.
- The PC practice indicated risk score status changes and shared integrated care was delivered with follow up appointments.

- The PC practice demonstrated its ability to stratify data according to diversity (e.g., race, ethnicity).
- The PC practice has demonstrated commitment to delivering coordinated care management for behavioral health.
- The PC practice uses behavioral health care management services using shared care management resources, including health home care managers, and described a connection to behavioral health case management services.
- The PC practice demonstrated use and capability of sharing the care plan with other health care providers in electronic form and tracking patient progress. The PC practice provided screenshots of the process.
- The PC practice care team demonstrated integrated delivery through linkage with regional social services agencies (e.g., support groups) and produced a report detailing the previous three (3) months of interactions.
- The PC practice demonstrated follow up after depression and substance/alcohol abuse screening at regular intervals and referral tracking. The PC practice generated a three (3) - month follow-up report detailing the appropriateness and timeliness of follow up for applicable patients.
- The PC practice has demonstrated commitment to care plan development in concert with patient preferences and goals.
- The PC practice demonstrated that its patients have a care plan, noting patient goals and preferences for management of chronic disease in the patient record. The PC practice submitted documentation of patients with completed care plans in EHRs (patients with care plan as numerator and all empaneled patients as denominator).
- The PC practice showed capability of sharing the care plan with other health care providers in electronic form. The PC practice demonstrated improvement of the percentage of patients with a care plan, including evidence of shared care planning with other providers.
- The PC practice provided an operational process for systematically tracking patients throughout the referral process including behavioral health and substance abuse.
- The PC practice implemented clinical/non-clinical workflow patterns to track referrals sent, patients seen and consultation reports received with flagging of missing information.
    - The PC practice provided a three (3)-month de-identified EHR report or evidence of a referral tracking template used or other documentation of the operational process.
- The PC practice has demonstrated commitment to establishing care compacts or collaborative agreements for timely consultation with medical specialists and institutions.
- The PC practice established written care compacts with at least two (2) high volume specialists inside or outside of the practice ownership entity, or demonstrated a structured process for coordinated care of patients.
    - The PC practice described its communication, arrangements and copy of care compacts, or narrative process that includes expectations of both parties creating a “closed loop” in patient care.
- The PC practice’s care compacts or description of a structured process includes primary/specialty care expectations, access to care, collaborative care management, patient communication needs and provision of patient transition records.
    - The PC practice provided measures of referrals completed as numerator and referrals made as denominator, and demonstrated improvement in a three (3)-month period.
- The PC practice has demonstrated commitment to creating a post discharge follow up process for timely transitions in care.
- The PC practice developed and documented a process to receive timely notifications (e.g., emergency departments, hospitals).
- The PC practice reviews discharge summaries for missing information (e.g., pursues gaps in discharge communication), and demonstrated review and reconciliation of medications of 50% of discharged patients for a three (3)-month period.

- The PC practice demonstrated contact of discharged patients within 72 hours and discharges requiring patient contact. The PC practice schedules and documents follow up within seven (7) days or as applicable. The PC practice provided a report showing improvement over a three (3) month period including all patients where follow up was made as numerator and all known discharges as denominator.
- The PC practice identifies patients who will need internal case management/case coordination or who will require coordination of care from other health or community-based services. The PC practice provided examples of at least two (2) de-identified patients with TCM/CCM coding utilization shown during a six (6) month period.

Milestone 4 – Access to Care

- The PC practice has demonstrated commitment to providing at least one (1) session weekly during non-traditional hours.
- The PC practice provides a minimum of one (1) non-traditional weekly session of scheduled services defined as before 8:00 a.m. or after 6:00 p.m., and/or weekends. The PC practice provided the ratio of patients seen in non-traditional session(s) to patients seen during normal business hours in a six (6) month period, and provided a narrative of how improvement was achieved.
- The PC practice reviewed hours of operations and scheduling patterns to determine the most successful course in optimization of one (1) non-traditional weekly session. The PC provided a narrative describing its selection of visit types (e.g., 15-minute risk calls, annual physicals, post-discharge follow ups) and time slot templates for the session.

Milestone 5 – HIT

- The PC practice demonstrated commitment to utilizing tools for quality measurement encompassing all core measures and securing electronic provider-patient secure messaging.
- The PC practice is able to provide 24/7 remote access through HIT, including secure electronic provider/patient messaging; information exchange including reconciliation and incorporation of exchanged information using EHR technology certified to 170.314(b) (4); enhanced quality improvement including Clinical Decision Support (CDS); certified HIT for quality improvement and information exchange; and connection to the local Regional Health Information Organization (RHIO).
    - The PC practice provided verification of transitions of care for receiving, displaying and incorporating transition of care/referral summaries including sharing Advanced Directives.
    - The PC practice provided verification of clinical information and medication reconciliation, incorporating lab values and test results; recording immunizations and transmitting to the immunization registry; and clinical decision support interventions that have been enabled.
    - The PC practice provided a transmission report or letter from the RHIO that shows certification of connection.

Milestone 6 – Payment Model

- The PC practice has demonstrated commitment to value-based gain sharing contracts with APC-participating payers representing 60% of the panel.
- The PC practice has signed contracts meeting the criteria of representing 60% of the panel.
    - The PC practice provided a report of patients attributed to Advanced Primary Care (APC) participating payers as numerator and total patients attributed to the practice as denominator.

- The PC practice provided a report of the number of patients attributed to each APC-participating payer.
- The PC practice provided a report on the total current empaneled patients.

Milestone 7 – Population Health

- The PC practice has demonstrated commitment to participating in Prevention Agenda activities.
- The PC practice participated in local county health collaborative, Prevention Agenda meetings and participated in at least two (2) activities with Prevention Agenda partners on shared priority efforts (e.g., integrating pre-conception care, efforts to promote behavioral health well-being). The PC practice discussed shared goals/priorities with its local health department.
- The PC practice demonstrated commitment to identification and outreach to patients due for preventive and chronic care management.
- The PC practice documented clinical decision support interventions that have enabled staff workflows, its process for identifying patients due for preventive and chronic care visits (e.g., preventive screenings) and its use of clinical guidelines for chronic care conditions, including methods of follow up used. The PC practice provided evidence of how its preventive measures (screening) are being tracked.
- The PC practice demonstrated commitment to creating a process to refer to structured health education programs and community based resources.
- The PC practice provided evidence for how it provides and tracks referrals to community-based organizations; and its resources for patients with chronic conditions, social and behavioral health needs (e.g., screenshots of logs or EHR showing referral tracking).

Note: In conjunction with the PT TA Organization, Health Research, Inc. (HRI)/New York State Department of Health (NYSDOH) will provide the PC practice with information on structured health education programs and other resources including local health departments, the local Office for the Aging, the Performing Provider Systems (PPS) community resource compendium and the Population Health Improvement Program (PHIP).

Attachment 8:
Practice Transformation Technical Assistance Services Contract
Gate Assessment Tool

For Gates 2 and 3, the Contractor will use the "Gate Assessment Tool" to conduct a Gate assessment for each enrolled PC practice at least once every 12 months. The PC practice can have no more than two (2) Gate assessments per year, per Gate, with at least two (2) months between Gate assessments. The Gate assessments are subject to audit and quality control by the IVA.

Guidance will be provided to the Contractor to verify accomplishments of PC practices that completed certain Gate 2 Milestones under 1.) National Committee for Quality Assurance (NCQA), Patient Centered Medical Home (PCMH) 2014 Standards; 2.) Transforming Clinical Practice Initiative (TCPI), Practice Transformation Network (PTN), Practice Assessment Tool (PAT); and/or 3.) Electronic Health Record, Meaningful Use, Stage 1 or 2. These accomplishments, when formally verified by the Contractor, may serve as credit for completing the applicable Gate 2 Milestones.

Practice Transformation Technical Assistance Services Contract
Gate Assessment Tool

Gate 2:

Milestone	Completed (√)
Milestone 1 - Participation	
One (1) PC practice lead or their designee has successfully participated in each of the Contractor's learning activities and has provided attendance records to the Contractor.	
Milestone 2 – Patient-Centered Care	
The PC practice has demonstrated commitment to patient engagement activities and has integrated the activities into its work flows within one (1) year.	
The PC practice has submitted an acceptable plan for a patient satisfaction survey, focus group or Patient-Family Advisory Council (PFAC) that includes representation from the PC practice's served populations. The plan includes design of a charter, the survey instrument (if applicable), the patient selection process and staff orientation.	
The PC practice has demonstrated commitment to AD discussion with all patients older than age 65.	
The PC practice uses protocols/processes with the goal of reporting ADs on all patients older than age 65.	
The PC practice has submitted an acceptable narrative description of how it uses protocols/processes to engage and record ADs for eligible patients.	
The PC practice has submitted an acceptable three (3)-month spreadsheet or EHR-generated report that shows the number of patients with an AD in their chart (numerator) and all eligible patients seen in one (1) year (denominator), all declined responses (numerator and denominator) and mechanism for flagging reminders in a paper chart or EHR template.	
Milestone 3 - Care Management/Care Coordination	
The PC practice has demonstrated commitment to identify its highest risk patients for care management.	
The PC practice assigns patients to a specific provider care team (small practices may serve as their own care team). Active patients (i.e., last seen within two [2] years) are assigned to a provider.	
The PC practice has implemented a Risk Stratification System for care management using a standardized tool (e.g., American Academy of Family Physicians [AAFP], Agency for Healthcare Research & Quality [AHRQ]) or their own developed process to define and track high-risk patients. The PC practice has generated a consecutive, six (6)-month report with all empaneled patients (numerator) and all active patients (denominator).	
The PC practice has annotated risk scores for easy staff/provider access and identified a care management intervention on at least 1% of its highest-risk patients in the entire panel. The PC practice has named and described its Risk Stratification tool and generated a consecutive, six (6)-month report or spreadsheet that identifies highest-risk patients by risk score.	
The PC practice has demonstrated commitment to planning for care management and/or care coordination delivery within one (1) year.	
The PC practice implements recruitment strategies and/or appropriate training for existing staff regarding care management/care coordination delivery in a practice setting. Care management/care coordination needs are accomplished for at least 2% of the total empaneled population regardless of risk scores and/or highest need patients. • The PC practice created job description(s) for care management/care coordination roles that outline practice capacities and define percentage of	

effort/full-time equivalent (FTE) needs based on the PC practice's high-risk patient population. • The PC practice described provision of internal and external training (State-provided care management guidance). • The PC practice has submitted acceptable proof of implementation of transitional care management (TCM)/chronic care management (CCM) claims codes they are using.	
The PC practice has demonstrated commitment to integrating an evidence-based process for behavioral health screening, treatment and, where appropriate, referral.	
The PC practice uses PHQ2/PHQ9 for depression screening and a validated screening tool for substance/alcohol abuse, and has demonstrated appropriate screening of eligible adults older than age 18.	
The PC practice engages/participates in and completed an on-line or in-person training for behavioral health integration in PC settings that broadens team-based care and clinical treatment of depression.	
The PC practice has a collaborative care agreement with a behavioral health provider which includes the communication process and description of how patients are seen, treated and tracked. The PC practice has created/implemented a collaborative care agreement that defines tracking and follow up.	
The PC practice has a defined process of adherence to behavioral health quality measures (common score card).	
The PC practice has demonstrated commitment to having a process in place for care plan development.	
The PC practice has identified key components of a structured Care Plan that best fits its patients' needs with goals and preferences. The Plan includes a work flow chart or protocol that includes specific goals for patient engagement. • The PC practice has implemented at least three (3) nationally-recognized (e.g., AHRQ) or Contractor-approved Shared Decision-Making Tools with priority given to quality measures in the common measure set (e.g., colonoscopy, antibiotic use, back pain management, weight management, depression). • The PC practice has integrated the use of technology for record tracking and secure communication methodology, and educated patients regarding secure communication. • The PC practice has established structured Care Plans, including use of a template, tracking tool and criteria used to identify patient needs during Care Management/Care Coordination periods. The PC practice has provided an acceptable baseline EHR report or tracking tool showing the percentage of patients in a high risk category with a Care Plan.	
The PC practice has demonstrated commitment to systematically utilizing a referral tracking system.	
The PC practice has developed the capability for systematically tracking patients throughout referral processes. The PC practice has created clinical/non-clinical staffing workflow patterns to track referrals made, patients seen, consultation reports received and flagging of missing information. The PC practice has demonstrated that staff workflow assignments have been operationalized and have provided screenshots of their EHR referral tracking workflow.	
Milestone 4 – Access to Care	
The PC practice has demonstrated commitment to improving communication capabilities.	
The PC practice has improved communication capabilities by using secure communication methods or a nurse call-line for other non-urgent care. The PC practice assures navigation to other care coordination and referrals to educational resources (e.g., diabetes education tools, navigation to patient health questionnaires, proper utilization of emergency	

department vs. office visits).	
The PC practice has provided three (3) de-identified screenshots or examples that show acceptable patient communication for non-urgent care provided after hours through use of secure communication methods or a nurse call-line.	
The PC practice has demonstrated commitment to providing same day appointments.	
The PC practice has reviewed its hours of operation and scheduling patterns to determine the most successful method of ensuring same-day appointment availability. The PC practice has described its policy and process for same day appointments.	
The PC practice has provided an acceptable narrative on its method to assess and meet patient demands, including its policy and workflow assignments for maintaining schedules.	
The PC practice has assessed its demands for same day appointments with a goal to satisfy at least 80% of its patient demand. The PC practice has measured patients seen at same-day appointments (numerator) and patient phone calls requesting same-day appointments (denominator) and improvements in a three (3)-month period.	
The PC practice has demonstrated commitment to providing culturally and linguistically appropriate services.	
The PC practice has assessed the need, and developed an acceptable plan, to address population diversity and cultural needs.	
The PC practice has engaged interpretation services, as applicable to the practice's population needs including vision or hearing impaired.	
The PC practice provides preferred language materials (print and/or electronic) to patients that meet the practice's community needs.	
The PC practice has identified their panels by language and ethnicity for services intervention. The PC practice has provided a screenshot of documentation in EHR or spreadsheet/log. The PC practice has provided an example of printed materials used if the particular population group is greater than 5% of the panel.	
Milestone 5 - HIT	
The PC practice has demonstrated commitment to utilizing tools for quality measurement encompassing all core measures and to attesting to connect to HIE within one (1) year.	
The PC practice has the ability to capture, calculate and report all core measures, developed basic Information Exchange and committed to connect to HIE within one (1) year by establishing a participation agreement with their Regional Health Information Organization (RHIO).	
The PC practice has demonstrated certified health information: common clinical data set, demographics, vital signs, body mass index and growth charts and problem list.	
The PC practice has demonstrated clinical quality improvement: capture, calculate and report measures; active medication list; medication allergy list; smoking status; patient list creation; secure messaging; and view, download and transmit to third party.	
The PC practice has signed a RHIO participation agreement.	
Milestone 6 – Payment Model	
The PC practice has demonstrated commitment to contracts for minimum fee-for- service (FFS) with Pay for Performance (P4P) contracts with participating payers representing 40% of the panel with commitment to achieving 60%.	
The PC practice has signed contracts meeting the criteria representing 40% of the panel with a commitment to achieve 60%.	
The PC practice has provided a report of the number of patients attributed to each APC-participating payer or other reports that show the reach/impact of the contracts. The PC practice has submitted an acceptable report on its total current empaneled patients.	

Gate 3:

Milestone	Completed (√)
Milestone 1 - Participation	
The PC practice has continued to actively participate in PT TA services.	
Milestone 2 – Patient-Centered Care	
The PC practice has implemented patient engagement into its workflows including a Quality Improvement (QI) plan grounded in evidence-based criteria.	
The PC practice implemented and provided evidence of at least one (1) annual patient engagement strategy resulting in the use of at least one (1) QI project that will effect practice change. The PC practice demonstrated its process for incorporating care team staff, patients, families and/or community-based organizations into its strategy efforts (e.g., addressed patient wait times or patient-reported outcomes).	
The PC practice completed a patient survey for at least 8% of its discrete patients at two (2), six (6)-month intervals and provided the results to its patients.	
The PC practice provided an acceptable report of the results and included its survey sample.	
The PC practice provided its area of QI selection and results on a quarterly basis if they used a focus group or PFAC, including sample agendas, meeting minutes and QI strategy results.	
The PC practice demonstrated commitment to sharing ADs across the medical neighborhood where feasible.	
The PC practice demonstrated that its ADs (including eMOLST) are made available in electronic form to share with other health care providers and exchanged through HIE. The PC practice submitted de-identified examples of this communication where feasible.	
Milestone 3 – Care Management/Care Coordination	
The PC practice has demonstrated commitment to integrate high risk patient data from other sources (including payers).	
The PC practice has a system in place to actively manage high risk patients and integrate high risk patient data from other sources (including payers). The PC practice manages high risk patients internally or by using a collaborative shared service organization model. o The PC practice provided evidence of actively managing high risk patients (e.g., through EHR, spreadsheet for patient panel or improved risk scores).	
The PC practice has demonstrated commitment to delivering care management to its highest risk patients.	
The PC practice has ensured that all high risk patients are offered care management through the PC practice, a contracted entity or other identified specialty practice.	
The PC practice has demonstrated care management/care coordination integrated delivery through introduction of services (potentially acquired through shared service organizations), such as nutritional care, pharmacy and behavioral health specialties.	
The PC practice conducts structured huddles/meetings to discuss cases with the care team.	
The PC practice provides structured outreach/protocols in care transition settings, including "back to home."	
The PC practice engages/conducts trainings for use of payer utilization reports of high risk patients. o The PC practice provided an acceptable narrative description of its use of payer utilization reports to identify/compare high risk patients as defined by the PC practice.	
The PC practice provided evidence of three (3) consecutive months of de-identified case management logs or EHR reports regarding continued care and use of TCM/CCM claim codes.	
The PC practice indicated risk score status changes and shared integrated care was delivered with follow up appointments.	

The PC practice demonstrated its ability to stratify data according to diversity (e.g., race, ethnicity).	
The PC practice has demonstrated commitment to delivering coordinated care management for behavioral health.	
The PC practice uses behavioral health care management services using shared care management resources, including health home care managers, and described a connection to behavioral health case management services.	
The PC practice demonstrated use and capability of sharing the care plan with other health care providers in electronic form and tracking patient progress. The PC practice provided screenshots of the process.	
The PC practice care team demonstrated integrated delivery through linkage with regional social services agencies (e.g., support groups) and produced a report detailing the previous three (3) months of interactions.	
The PC practice demonstrated follow up after depression and substance/alcohol abuse screening at regular intervals and referral tracking. The PC practice generated a three (3) - month follow-up report detailing the appropriateness and timeliness of follow up for applicable patients.	
The PC practice has demonstrated commitment to care plan development in concert with patient preferences and goals.	
The PC practice demonstrated that its patients have a care plan, noting patient goals and preferences for management of chronic disease in the patient record. The PC practice submitted documentation of patients with completed care plans in EHRs (patients with care plan as numerator and all empaneled patients as denominator).	
The PC practice showed capability of sharing the care plan with other health care providers in electronic form. The PC practice demonstrated improvement of the percentage of patients with a care plan, including evidence of shared care planning with other providers.	
The PC practice provided an operational process for systematically tracking patients throughout the referral process including behavioral health and substance abuse.	
The PC practice implemented clinical/non-clinical workflow patterns to track referrals sent, patients seen and consultation reports received with flagging of missing information. o The PC practice provided a three (3)-month de-identified EHR report or evidence of a referral tracking template used or other documentation of the operational process.	
The PC practice has demonstrated commitment to establishing care compacts or collaborative agreements for timely consultation with medical specialists and institutions.	
The PC practice established written care compacts with at least two (2) high volume specialists inside or outside of the practice ownership entity, or demonstrated a structured process for coordinated care of patients. o The PC practice described its communication, arrangements and copy of care compacts, or narrative process that includes expectations of both parties creating a "closed loop" in patient care.	
The PC practice's care compacts or description of a structured process includes primary/specialty care expectations, access to care, collaborative care management, patient communication needs and provision of patient transition records. o The PC practice provided measures of referrals completed as numerator and referrals made as denominator, and demonstrated improvement in a three (3)-month period.	
The PC practice has demonstrated commitment to creating a post discharge follow up process for timely transitions in care.	
The PC practice developed and documented a process to receive timely notifications (e.g., emergency departments, hospitals).	
The PC practice reviews discharge summaries for missing information (e.g., pursues gaps in discharge communication), and demonstrated review and reconciliation of medications of	

50% of discharged patients for a three (3)-month period.	
The PC practice demonstrated contact of discharged patients within 72 hours and discharges requiring patient contact. The PC practice schedules and documents follow up within seven (7) days or as applicable. The PC practice provided a report showing improvement over a three (3) month period including all patients where follow up was made as numerator and all known discharges as denominator.	
The PC practice identifies patients who will need internal case management/case coordination or who will require coordination of care from other health or community-based services. The PC practice provided examples of at least two (2) de-identified patients with TCM/CCM coding utilization shown during a six (6) month period.	
Milestone 4 – Access to Care	
The PC practice has demonstrated commitment to providing at least one (1) session weekly during non-traditional hours.	
The PC practice provides a minimum of one (1) non-traditional weekly session of scheduled services defined as before 8:00 a.m. or after 6:00 p.m., and/or weekends. The PC practice provided the ratio of patients seen in non-traditional session(s) to patients seen during normal business hours in a six (6) month period, and provided a narrative of how improvement was achieved.	
The PC practice reviewed hours of operations and scheduling patterns to determine the most successful course in optimization of one (1) non-traditional weekly session. The PC provided a narrative describing its selection of visit types (e.g., 15-minute risk calls, annual physicals, post-discharge follow ups) and time slot templates for the session.	
Milestone 5 - HIT	
The PC practice demonstrated commitment to utilizing tools for quality measurement encompassing all core measures and securing electronic provider-patient secure messaging.	
The PC practice is able to provide 24/7 remote access through HIT, including secure electronic provider/patient messaging; information exchange including reconciliation and incorporation of exchanged information using EHR technology certified to 170.314(b) (4); enhanced quality improvement including Clinical Decision Support (CDS); certified HIT for quality improvement and information exchange; and connection to the local Regional Health Information Organization (RHIO). • The PC practice provided verification of transitions of care for receiving, displaying and incorporating transition of care/referral summaries including sharing Advanced Directives. • The PC practice provided verification of clinical information and medication reconciliation, incorporating lab values and test results; recording immunizations and transmitting to the immunization registry; and clinical decision support interventions that have been enabled. • The PC practice provided a transmission report or letter from the RHIO that shows certification of connection.	
Milestone 6 – Payment Model	
The PC practice has demonstrated commitment to value-based gain sharing contracts with APC-participating payers representing 60% of the panel	
The PC practice has signed contracts meeting the criteria of representing 60% of the panel. • The PC practice provided a report of patients attributed to Advanced Primary Care (APC) participating payers as numerator and total patients attributed to the practice as denominator. • The PC practice provided a report of the number of patients attributed to each APC-participating payer. • The PC practice provided a report on the total current empaneled patients.	
Milestone 7 – Population Health	
The PC practice has demonstrated commitment to participating in Prevention Agenda	

activities.	
The PC practice participated in local county health collaborative, Prevention Agenda meetings and participated in at least two (2) activities with Prevention Agenda partners on shared priority efforts (e.g., integrating pre-conception care, efforts to promote behavioral health well-being). The PC practice discussed shared goals/priorities with its local health department.	
The PC practice demonstrated commitment to identification and outreach to patients due for preventive and chronic care management.	
The PC practice documented clinical decision support interventions that have enabled staff workflows, its process for identifying patients due for preventive and chronic care visits (e.g., preventive screenings) and its use of clinical guidelines for chronic care conditions, including methods of follow up used. The PC practice provided evidence of how its preventive measures (screening) are being tracked.	
The PC practice demonstrated commitment to creating a process to refer to structured health education programs and community based resources.	
The PC practice provided evidence for how it provides and tracks referrals to community-based organizations; and its resources for patients with chronic conditions, social and behavioral health needs (e.g., screenshots of logs or EHR showing referral tracking).	

Quarterly Reports

The Contractor will submit quarterly reports to the HRI/NYSDOH Contract Manager and IVA on PC practice achievement of APC Gates and Milestones. The report templates will be provided to the Contractor in Excel.

The following summarizes the required Quarterly Reports and their elements:

1. Gate Progress Report

This report requires the Contractor's name, Year Number, Quarter Number, a listing of PC practices with their practice identification (ID) code (Unique ID [UID] Number) which is assigned by the "PT Tracking System" and their enrollment (on-boarding) date.

- Gate 1: The Contractor should indicate the date that the PC practice completed its forms and the date that all other tasks were completed.
- Gates 2 and 3: The Contractor should indicate the percentage of progress (0-25%, 26-50%, 51-75% or 76-100%). The Contractor should color-code the cell according to progress made from baseline through quarter completion.

2. Milestone Summary Report

This report requires the Contractor's name, Year Number, Quarter Number and a listing of PC practices with their UID Number.

- For each applicable Gate, the Contractor should indicate the "Gating" date and enter a "1" if the Milestone has been completed.

3. Data Dashboard Report

This **cumulative** report requires the Contractor's name, Year Number and Quarter Number. The Contractor should enter practices' name, date of enrollment (on-boarding), DFS region, street address, city and nine (9)-digit zip code.

For each practice, including those not receiving PT TA services and only being "Gated," the Contractor should enter the number of professional staff for each category provided (providers, mid-level Physician Assistants, mid-level Nurse Practitioners, behavioral health and other specialty, as applicable). The total number will calculate automatically.

For each practice, the Contractor should enter the total estimated number of beneficiaries of all payers.

For each practice, the Contractor should enter the estimated payer mix (to be provided by the HRI/NYSDOH Contract Manager). The total number will calculate automatically and should equal 100%.

For each practice, the Contractor should enter the total number of hours it spent providing deliverables (on-site coaching, learning collaboratives, group trainings and remote support). The total number of hours delivered will calculate automatically.

4. Narrative Report

This report requires a description of general obstacles and/or barriers to PT TA services efforts. The Contractor should summarize only those areas requiring assistance, mitigation or resolution from the HRI/NYSDOH Contract Manager.

The Contractor should enter general comments at the top of the form, the Contractor's name, Year Number

and Quarter Number.

By topic area (practice recruitment, start-up barriers, curriculum deliverables, milestone deliverables, pacing/general progress concerns, region-specific concerns and other), the Contractor should enter comments.

By practice UID Number, the Contractor should enter comments and a summary of remediation, change plan, etc.