Better Health
for Northeast New York
A Partnership for Better Health

DSRIP PARTNER REPORTING GUIDE

For BHNNY Partners: An overview of process and requirements to report to PPS lead to earn payments

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STYLE GUIDE

PURPOSE

The purpose of this document is to provide guidance and support for partners preparing to submit proof of performance activity completion in order to earn payment for the Phase II Contracting period.

Partners will be awarded their DSRIP payments based on their ability to demonstrate completion of performance activities, following the instructions laid out in this manual and any specific requirements of their selected project(s).

GENERAL GUIDANCE

- The Project Activity Schedule (Attachment A) can be used as a reference for reporting requirements and deadlines to submit documentation. Due to changes in deadlines from the State that may trickle down to partners, please refer to the Project Activity Schedule for the most up-to-date deadlines and reporting requirements. Any dates in the activity schedule document will supersede dates in the partner reporting templates, unless otherwise communicated by BHNNY PPS.

- Partner Reporting Templates (Excel document) have been created to include a section for each reporting period (periods 1, 2, and 3). BHNNY will email partners their personalized reporting templates each reporting period, which will be updated to include previous reporting and scores. All partners will submit their **most updated Partner Reporting Template** each reporting period, summarizing their achievement for payment against each performance activity. Partners should use only the reporting template that is emailed to them by BHNNY PPS each period, to ensure they are submitting the most updated version.

- Each performance activity reported for payment must be accompanied by a supporting documentation file, as applicable and when requested by the PPS.

- **Supporting documentation (except excel documents) must be submitted as a single PDF file per applicable performance activity.** For example, if a performance activity requires a sign-in sheet, agenda, and meeting notes, all of these documents would be consolidated into a single PDF that will be submitted as the supporting documentation for that performance activity.

- BHNNY PPS may develop templates to meet reporting requirements during any payment period. Under these circumstances, BHNNY PPS will communicate and share these templates with partners well in advance before the reporting deadline.

- Each performance activity will require a reporting **template or other supporting documents *(if applicable)*** to be uploaded to MOVEit by the specified reporting date. Some templates will be provided by the PPS. All supporting documentation requirements can be found in the "Project Activity Schedule" found at the end of this reporting guide (Attachment A).

- A reporting attestation coversheet will be required for each payment period.

- If applicable, highlight requested information within supporting documentation (i.e. date of hire in offer letter for a performance activity that requires someone be hired by the completion date). This will help BHNNY PPS confirm that all requested information is in the document.

- Partners **MUST** include dates in supporting documentation to prove achievement occurred by the PPS's specified completion date. The date of achievement can be specified within the supporting document itself (e.g. in the footer, date of meeting, etc.).

- Handwritten notes will not be accepted (other than sign-in sheets).

- PHI should only be included when relevant or prudent to the performance activity (i.e. patient engagement templates, data registry templates, etc.). If you have any questions about when PHI should or should not be included in supporting documentation, please reach out to Chrissy McIntyre at McintyC@mail.amc.edu.

- Marketing and communication (e.g. newsletters) materials/community materials should be included when used.

REPORTING REQUIREMENTS THAT APPLY TO ALL PERFORMANCE ACTIVITIES:

DOCUMENTING PERFORMANCE ACTIVITES

- Every organizational internal meeting and/or brainstorming/planning session relevant to completion of a required performance activity should have an agenda, attendee list, and notes/minutes. If it is a meeting hosted by the PPS, BHNNY PPS will make minutes available to partners, and partners will not be required to submit these as documentation for such meetings.

- Every hire should have a hire letter or other Human Resource document to support completion of applicable performance activities.

- Every patient interaction should be captured in the EHR or an applicable file.

ORGANIZING DOCUMENTATION

- Keep all documents in a central, secure, place

- Any additional information that might be used in supporting documentation may be included, and it will be at the PPS's discretion to determine if it supports the performance activity or not.

WHICH PERFORMANCE ACTIVTIES TO REPORT

Partner is responsible for understanding which performance activities it is accountable for performing and reporting to BHNNY when it signs a contract with attached Exhibit A. Generally:

- Exhibit A lists the performance activities the partner is contractually committed to report.
- Partner can refer to the individualized Partner Reporting Template received via email from BHNNY, which summarizes performance activities it must report on and for which it must submit documentation.
- Partner must report on all applicable performance activities. Deliverables for each organization are based on project participation and provider service type.
- All supporting documentation requirements including quarterly reporting template for registries and patient engagement must be submitted to BHNNY PPS 10 days after the completion date (or earlier) for performance activities. This information is found in the Project Activity Schedule (Attachment A).
- Completed Reporting Templates are due to the PMO by April 10, 2017 (Payment Period 1), October 10, 2017 (Payment Period 2) and April 10, 2018 (Payment Period 3) demonstrating and attesting that performance activities were completed and submitted by the specified completion date.

NAMING CONVENTIONS

As described further below, supporting documentation will be submitted via MOVEit, a secure online portal for file transfer. All Word and PowerPoint documents are to be saved and submitted as a **PDF**, and all templates are to be submitted as an Excel workbook **(do not save as PDF).** Please save supporting documentation with the naming conventions in the table below.

Supporting Documentation Type	Naming Convention	Example
Excel Templates	Partner Name_Template Name_Completion Date	ABC Hospital_Patient Engagement Template_03312017
Other	Partner Name_Activity_ID_Completion Date	ABC Hospital_P_006_03312017

DEFINITIONS:

Partner Name: Please use the standardized name provided in your Master Project Agreement. If your organization name is too long and you encounter problems while saving due to length of name, please truncate appropriately and keep the naming convention consistent across all saved documents.

Activity_ID: Refer to the tables in Exhibit A, reporting template, and/or the Project Activity Schedule (Attachment A)

Template Name: The name of the template that has been provided by BHNNY

Completion Date: The PPS defined completion date found in reporting template and Project Activity Schedule (Attachment A). Date format should be as follows: mmddyyyy

TIMELINES

KEY DATES & DEADLINES

- **March 31, 2017:** BHNNY Reporting Templates for supplemental documentation and reporting guidance are available at http://www.albanymedpps.org/Finance.cfm in the additional documents section.
- **April 10, 2017**: Final date that BHNNY will accept **completed reporting template** and supporting documentation for Payment Period 1, Phase II Q1. Partner must upload all documentation to the MOVEit site by end of business day. Late submissions may result in no payment to the partner. Instructions on accessing and submitting documents through the MOVEit site in the "Documentation Process" section of this Reporting Guide. The instructions will also be available at http://www.albanymedpps.org/Finance.cfm in the additional documents section.
- **April 20, 2017**: Final date to submit all remediation period requests for Payment Period 1.
- **July 10, 2017:** Final date that BHNNY will accept partner supporting documentation for Payment Period 2, Phase II Q2. Partner must upload all supporting documentation to the MOVEit site by end of business day. Late submissions may result in no payment to the partner. Instructions on accessing and submitting documents through the MOVEit site are found in the "Documentation Process" section of this Reporting Guide. The instructions will also be available at http://www.albanymedpps.org/Finance.cfm in the additional documents section.
- **October 10, 2017:** Final date that BHNNY will accept **completed reporting template** for Payment Period 2, Phase II Q2 & Q3 and supporting documentation for Payment Period 2, Phase II Q3. Partner must upload all documentation to the MOVEit site by end of business day. Late submissions may result in no payment to the partner. Instructions on accessing and submitting documents through the MOVEit site are found in the "Documentation Process" section of this Reporting Guide. The instructions will also be available at http://www.albanymedpps.org/Finance.cfm in the additional documents section.
- **October 20, 2017:** Final date to submit all remediation period requests for Payment Period 2.
- **January 10, 2018:** Final date that BHNNY will accept partner supporting documentation for Payment Period 3, Phase II Q4. Partner must upload all supporting documentation to the MOVEit site by end of business day. Late submissions may result in no payment to the partner. Instructions on accessing and submitting documents through the MOVEit site are found in the "Documentation Process" section of this Reporting Guide. The instructions will also be available at http://www.albanymedpps.org/Finance.cfm in the additional documents section.
- **April 10, 2018:** Final date that BHNNY will accept **completed reporting template** for Payment Period 3, Phase II Q4 & Q5 and supporting documentation for Payment Period 3, Phase II Q5. Partner must upload all supporting documentation to the MOVEit site by end of business day. Late submissions may result in no payment to the partner. Instructions on accessing and submitting documents through the MOVEit site are found in the "Documentation Process" section of this Reporting Guide. The instructions will also be available at http://www.albanymedpps.org/Finance.cfm in the additional documents section.
- **April 20, 2018:** Final date to submit all remediation period requests for Payment Period 3.

See Phase II Reporting Timeline on next page for a summary of dates.

PHASE II REPORTING TIMELINE

<table>
<tr><th>Payment Period</th><th>Quarter</th><th>Completion Dates</th><th>Reporting Documentation Due</th><th colspan="2">Review and Remediation Period</th><th>Expected Payment</th></tr>
<tr><td>Payment Period 1</td><td>Q1</td><td>3/31/2017</td><td>4/10/2017</td><td colspan="2">4/10/2017 - 4/20/2017</td><td>5/2017</td></tr>
<tr><td rowspan="2">Payment Period 2</td><td>Q2</td><td>6/30/2017</td><td>7/10/2017*
Supporting documentation only</td><td colspan="2">n/a</td><td rowspan="2">11/2017</td></tr>
<tr><td>Q3</td><td>9/30/2017</td><td>10/10/2017</td><td colspan="2">10/10/2017 - 10/20/2017</td></tr>
<tr><td rowspan="2">Payment Period 3</td><td>Q4</td><td>12/31/2017</td><td>1/10/2018*
Supporting documentation only</td><td colspan="2">n/a</td><td rowspan="2">5/2018</td></tr>
<tr><td>Q5</td><td>3/31/2018</td><td>4/10/2018</td><td colspan="2">4/10/2018 - 4/20/2018</td></tr>
<tr><td></td><td></td><td>Partners must have completed each performance activity by its completion date</td><td>Partners submit reporting template and supporting documentation</td><td>BHNNY PPS PMO reviews partner reports and provides feedback to partners, as necessary</td><td>Partner Remediation Period and final submissions to BHNNY PPS PMO</td><td>BHNNY PPS Finance processes payments to partners based on final reporting approvals</td></tr>
</table>

**If any of the due dates fall on a weekend/holiday, the requirement will be due/fulfilled no later than the following business day.

DOCUMENTATION PROCESS

OVERALL REPORTING REQUIREMENTS

Each partner is expected to complete timely submission of comprehensive reporting documentation for all performance activities captured in Exhibit A of the Phase II contract with BHNNY via upload to MOVEit per reporting period.

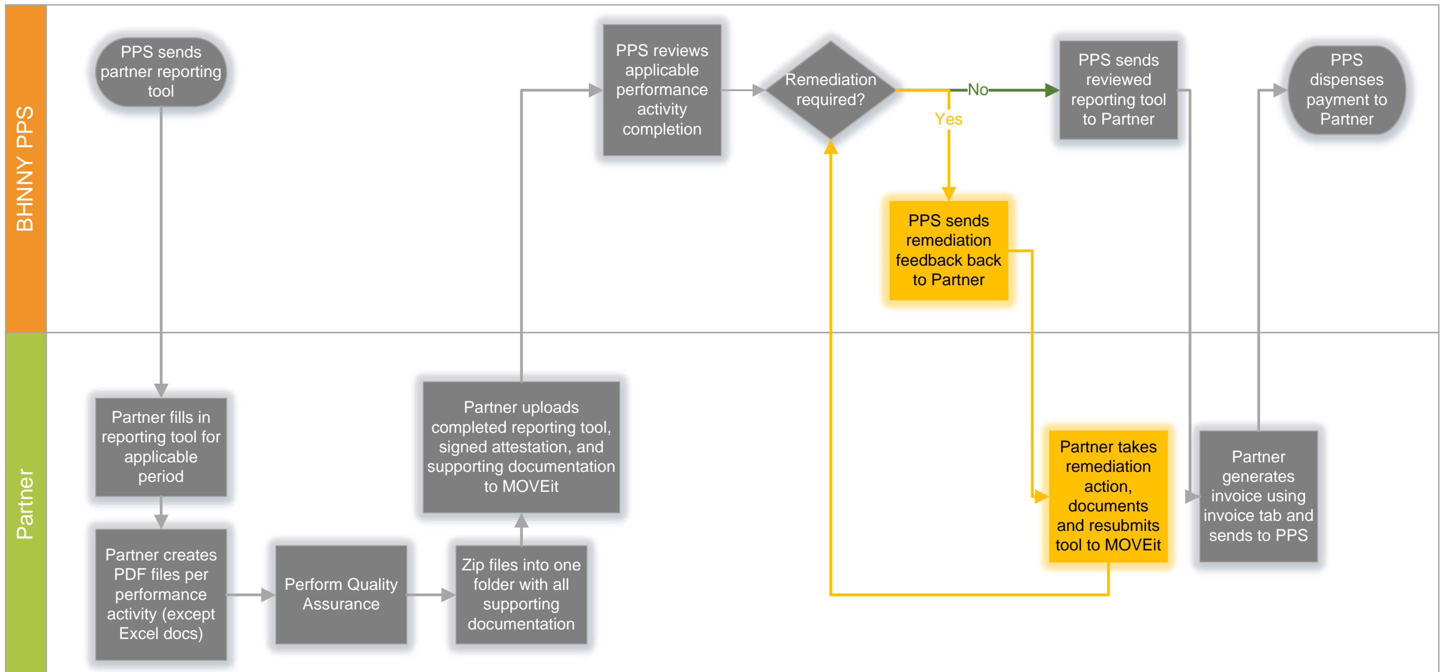
Reporting documentation to submit per reporting period includes:

1. One (1) signed and dated reporting attestation coversheet saved as a PDF
2. One (1) completed partner reporting template (Excel file) that covers all applicable performance activities for current Payment Period
3. Completed templates for all applicable performance activities. The same template may be used for multiple performance activities, if applicable. More information about this process is available in the "Other Templates" section below.
4. A single PDF packet that contains any other supporting documentation (excluding excel documents) per applicable performance activity

For example, Northern New York Hospital signed up to participate in 3.a.i Model 3 Integration of Primary Care and Behavioral Health Services and received a Phase II contract. This project has three performance activities in Payment Period 1 for partners with primary care services participating in project 3.a.i Model 3.

Northern New York Hospital's Exhibit A would include these three performance activities for project 3.a.i Model 3 to report on. The same performance activities are included in the Partner Reporting Template for Payment Period 1. One of these performance activities requires a copy of policy and procedures, one requires the name of a hired depression care manager with job description and an EMR screenshot, and the other requires the name of identified Psychiatrist(s) and copies of the protocols developed. Northern New York Hospital would need to submit one (1) PDF copy of policy and procedure, (1) PDF file of job description including name of hired depression care manager and EMR screenshot, and one (1) PDF file including name of identified Psychiatrist(s) and copies of protocols developed applicable to the performance activity. The partner would save each PDF file for applicable performance activity using the naming convention that is listed in the "Style Guide" section. This partner would upload these three (3) documents along with all other supporting documentation for applicable performance activities, a signed reporting attestation coversheet, and a completed partner reporting template for Payment Period 1.

REPORTING WORKFLOW



**Quarterly reports and other supporting documentation with earlier deadlines fall outside the scope of the workflow above

THE PARTNER REPORTING TEMPLATE

The purpose of this tool is to provide partners a comprehensive template to report on each of the performance activities they are contractually obligated to report on. The performance activities represented on the "Reporting Temp" tabs of the Reporting Tool match the performance activities in Payment Period 1, 2, and 3 that were listed in Exhibit A of the partner contracts.

Partners will be awarded their DSRIP payments based on their ability to demonstrate completion of milestone requirements, following the instructions laid out in the BHNNY Partner Reporting Guide. Ability to demonstrate completion of milestone requirements includes the partner accurately completing and submitting the reporting template back to BHNNY PPS no later than April 10, 2017 (Payment Period 1), October 10, 2017 (Payment Period 2), and April 10, 2018 (Payment Period 3).

INSTRUCTIONS FOR COMPLETING THIS TOOL

1. Complete all required surveys/questionnaires/templates/etc., and collect all supporting documentation. Please note that all supporting documentation needs to be saved using the naming convention that is listed in the "Style Guide" section.
2. Access the "Reporting Temp" tab for the current Payment Period of the Partner Reporting Template Excel document you received from BHNNY and complete the following sections:
   I. *Project Participation* - Please ensure that the list of projects is accurate for your organization. If you have any questions regarding the project list, please contact Chrissy McIntyre at McintyC@mail.amc.edu.
   II. *Prerequisite Performance Activities*– The performance activities listed here are specific to each partner based on their project participation and provider service type, and reflect the same performance activities listed in partner Exhibit A. Partners are contractually obligated to report on these performance activities. In the column labeled "**Completed by PPS defined Completion Date (Yes or No)**", please indicate with a "Yes" or "No" response if the performance activity has been completed by the completion date found in the column labeled "**Completion Date (MM/DD/YYY**)". Please list the file name of all applicable supporting documentation for each performance activity in the column labeled "**Supporting Documentation File Name, if Applicable**" following the required naming convention that is listed in the "Style Guide" section of this Partner Reporting Guide.
   III. *Stand Alone Performance Activities* - Please indicate performance activity completion with a "Yes" or "No" response in the column labeled "**Completed by PPS Defined Completion Date (Yes or No)**" if the performance activity has been completed by the completion date found in the column labeled "**Completion Date (MM/DD/YYY)**". Please list the file name of all applicable supporting documentation for each performance activity in the column labeled "**Supporting Documentation File Name, if Applicable**" following the required naming convention that is listed in the "Style Guide" section of this Partner Reporting Guide.
   IV. *Bundle Performance Activities* - Please indicate activity completion with a "Yes" or "No" response in the column labeled **"Completed by PPS Defined Completion Date (Yes or No)"** if the activity has been completed by the completion date found in the column labeled **"Completion Date (MM/DD/YYYY)"**. Please list the file name of all applicable supporting documentation for each activity in the column labeled **"Supporting Documentation File Name, if Applicable"** following the required naming convention that is listed in the "Style Guide" section of this Partner Reporting Guide.
   V. *Bundle Completion Payment* – No action is required from Project Participant. Completion will be determined by successful completion of all performance activities within each respective bundle and will automatically be calculated once requirements are met.

   Note:

   - Columns **N** through **T** of the Partner Reporting Template are for BHNNYY office use only and should not be edited by the partners. All editable cells are highlighted in **light grey**.
   - Columns **K** & **L** will only be used by partner during the remediation period if further action and supporting documentation is needed based on BHNNY PPS feedback from partner submission.
   - **DO NOT** change the name of the original excel file sent to partner from BHNNY PPS when uploading for submission. Partner must submit the Partner Reporting Template with the same naming convention as it had when originally sent to partner.
3. Upload completed Partner Reporting Template **in Excel**, along with applicable supporting documentation per performance activity and one PDF reporting attestation coversheet to MOVEit no later than **April 10, 2017** (Payment Period 1), **October 10, 2017** (Payment Period 2) and **April 10, 2018** (Payment Period 3). Any additional requests from BHNNY through the remediation period are due no later than April 15, 2017 (reporting period 1), October 15, 2017 (reporting period 2) and April 15, 2018 (reporting period 3

4. BHNNY PPS review partner submission of Reporting Template. Each performance activity will receive a score of R, Y, or G in Column **N**. For any performance activities that receive an R or a Y, BHNNY PSP will provide comments in Column **O**.
5. During the Remediation Period, partner will list any additional actions and supporting documentation requested by BHNNY PPS in additional columns **K** & **L**.
6. This template includes a tab for all applicable Outcome Measures that partner has been identified to impact. Partner will not need to complete this tab. BHNNY PPS will complete this tab for partners once NYSDOH provides outcome results in 2018 to calculate partner Outcome Measure payment.

WHERE TO FIND THE COMPREHENSIVE REPORTING TEMPLATE & OTHER TEMPLATES

The Partner Reporting Template was provided by BHNNY on April 3, 2017. If your organization did not receive a reporting template, please email Chrissy McIntyre at McintyC@mail.amc.edu.

Patient Registry, Patient Engagement and any other applicable templates can be found at http://www.albanymedpps.org/Finance.cfm in the additional documents section.

For assistance to identify or locate relevant reporting templates, please email Chrissy McIntyre at McintyC@mail.amc.edu.

HOW TO COMBINE FILES INTO A PDF

For each performance activity that requires supporting documentation that is not in the form of an excel document, partners must combine all documents as listed in the Project Activity Schedule (Attachment A) into a single PDF file for that performance activity. Partners should have the software capabilities to convert and combine multiple files into a PDF (typically provided by Adobe Acrobat, not Adobe Reader). **Do not save the excel templates provided by BHNNY as a PDF**.

TO SAVE WORD DOCUMENTS OR POWERPOINT RRESENTATIONS AS A PDF

File → *Save As* → *Save as Type* (dropdown under File name) → *PDF*

ADOBE HAS A COMBINE PDF OPTION WITHIN THE SOFTWARE

File → *Create* → *Combine Files into a Single PDF*

You can also combine files by selecting multiple files within a folder, right clicking, and selecting “Combine Files into a Single PDF”.

IF YOU DO NOT HAVE ADOBE ACROBAT OR OTHER APPROPRIATE SOFTWARE

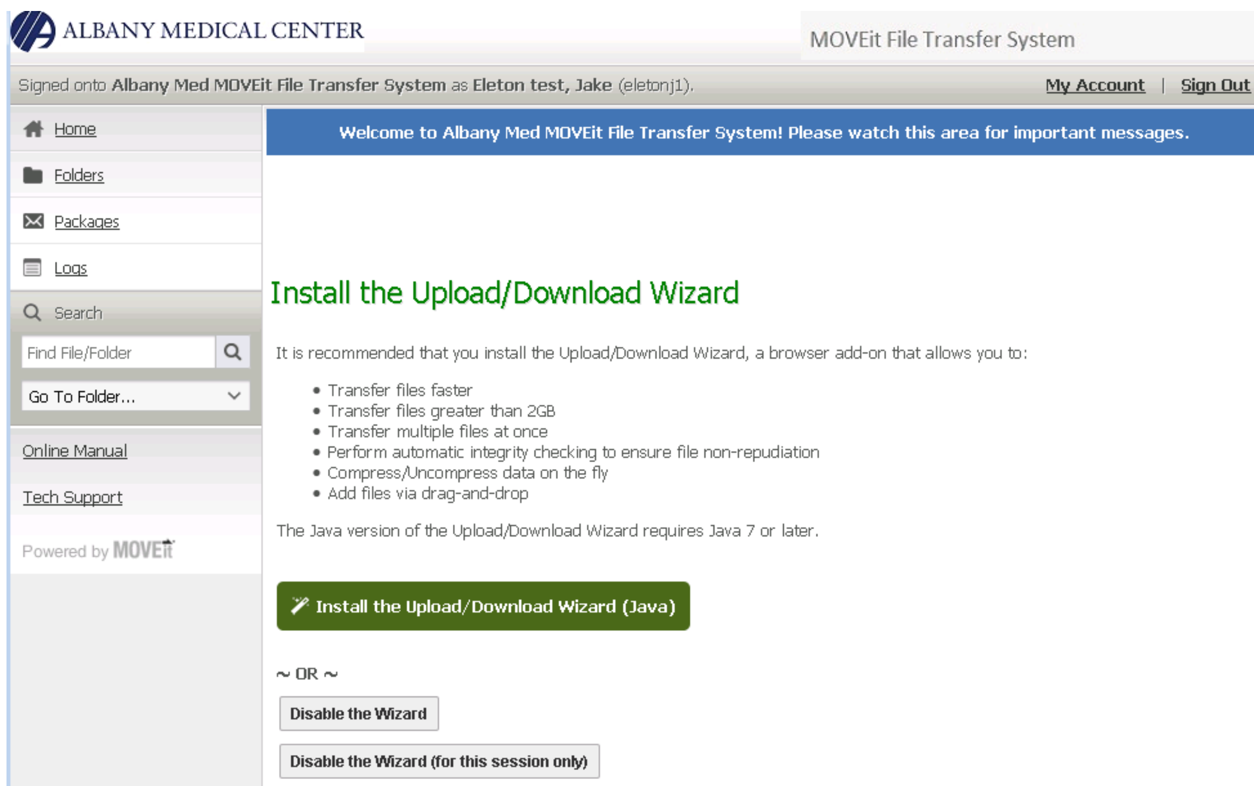
Print and scan the supporting documentation packet for applicable performance activities as one scanning project. This will transmit all documents as a single PDF file, which you can then name accordingly for that performance activity.

All files should follow the Naming Convention previously provided in the “Style Guide” section of this guideline document.

HOW TO LOG IN AND UPLOAD DOCUMENTATION TO MOVEIT

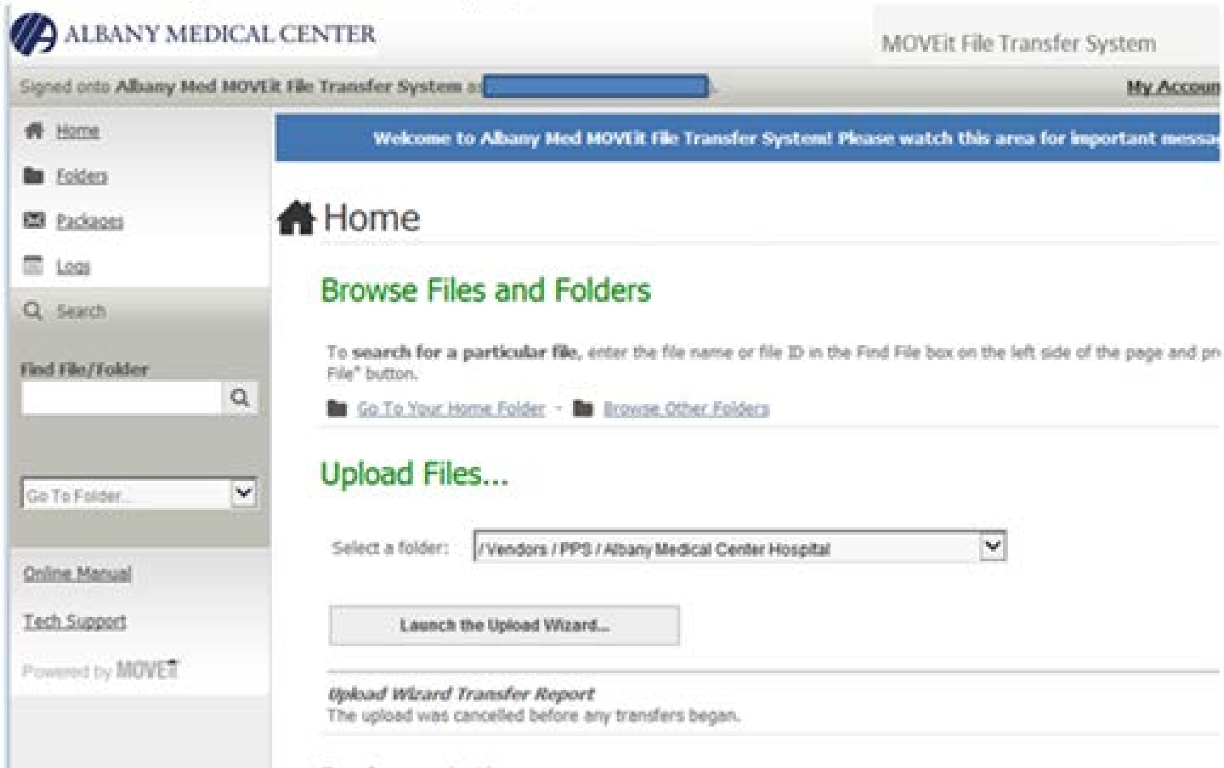
To access MOVEit, you must have a username and password, which must be requested through the BHNNY PMO. Organizations may have up to three active MOVEit users at any given time. Passwords expire every 90 days. Failure to reset your password within 90 days will result in your account being locked. To unlock your account and reset your password, contact the Help Desk at 518-262-5000. To unlock the password, you will need your PIN number. Keep this PIN in a secure location.

1. Log in, using your BHNNY credentials, at https://sft.amc.edu/.
   1.1 On the left of the page there is a navigation menu where you can go to your 'Folders', 'Packages', home page or 'Logs'.

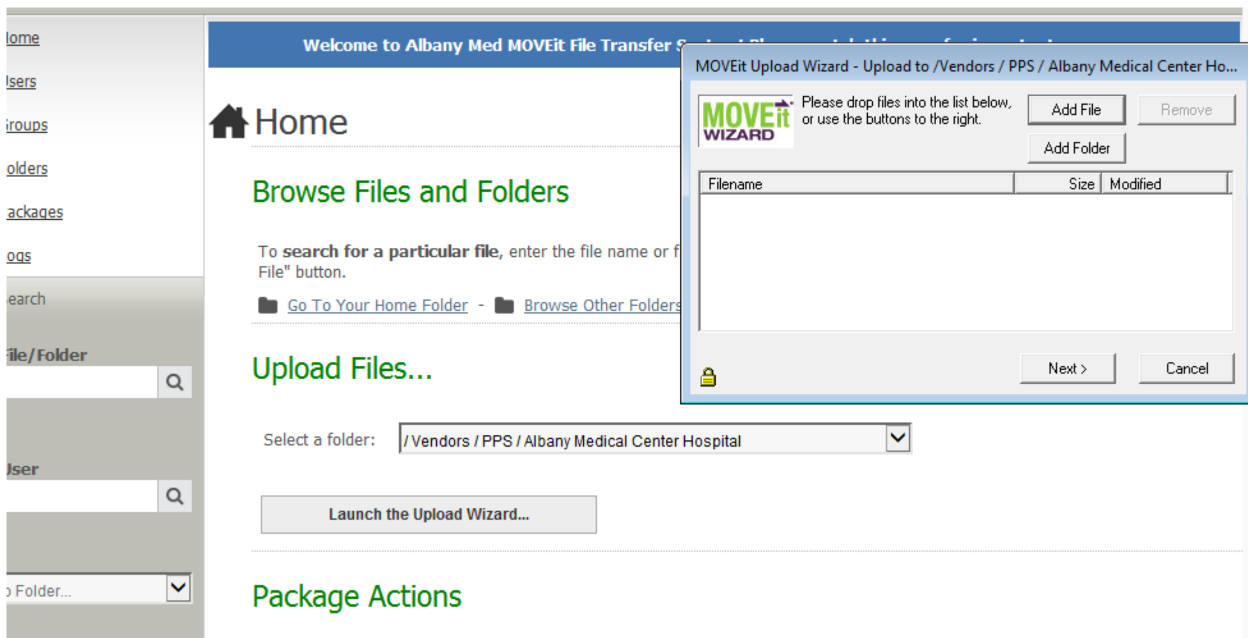


1.2 Installing the Upload/Download Wizard may be optional depending on your environment, though the functionality remains the same regardless of the Wizard being downloaded.

1.3 If disabling the Wizard, the option to upload to the shared folder will be presented on the home page.

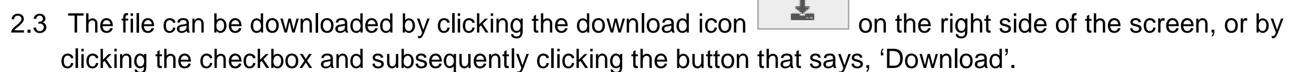


1.4 Alternatively, a means to upload files through the wizard will be presented after downloading/enabling and launching the wizard.



2. **Folders**: The ‘Folders’ area allows access to the shared location to upload/download files to/from the area designated for your PPS.
    - 2.1.1 Click ‘Folders’ on the left of the screen and navigate to your shared folder (Alternatively, from the home page click ‘Go To Your Home Folder’)
    - 2.1.2 Two subfolders will be listed under the main folder, ‘ToAMC’ and ‘FromAMC’
        - 2.1.2.1 The ToAMC folder is to be utilized by partners of the PPS to upload files for BHNNY to retrieve. Uploaded documents will flow here automatically. Please upload documents in one Zip File format.
        - 2.1.2.2 The FromAMC folder is for the BHNNY team to send files out to the PPS partners who will be able to download the files. Should BHNNY send you a file through MOVEit, you will receive an email notification to the email linked to your account.

2.2 After the file is uploaded, it will appear listed in the folder.

2.3 The file can be downloaded by clicking the download icon  on the right side of the screen, or by clicking the checkbox and subsequently clicking the button that says, ‘Download’.

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REPORTING ATTESTATION COVERSHEET

REPORTING ATTESTATION COVERSHEET INSTRUCTIONS

Purpose

A Reporting Attestation Coversheet will facilitate the oversight required by NYS guidelines and reporting requirements. It includes an attestation of the validity and accuracy of submitted documentation.

What is in the Reporting Attestation Coversheet?

The coversheet will have your organization's name, performance period dates, and attestation sections pre-populated. Each partner will have to fill in the appropriate payment period, partner reporting liaison, and quality officer names.

When do I include a Reporting Attestation Coversheet?

One Reporting Attestation Coversheet is required of each partner **per payment period**. This coversheet should be printed, signed, saved as a PDF and submitted via MOVEit. A screenshot of the coversheet has been included above.

Who is the Partner Reporting Liaison?

Each partner is responsible for designating an internal partner reporting liaison who will be the primary point of contact for reporting purposes. This individual will also be accountable for ensuring that all reports and supporting documentation files are accurate. The liaison will need to sign off on the entire submission per payment period. **The partner reporting liaison must be different from the designated quality assurance officer.**

Who is the Quality Assurance Officer?

Each partner is responsible for designating an internal quality assurance officer who will sign off on each payment period submission, attesting that the partner has approved the documentation and is ready for submission to BHNNY/NYSDOH. **The quality assurance officer must be different from the designated partner reporting liaison.**

Please ensure the reporting liaison and quality officer sign the Reporting Attestation Coversheet. An unsigned coversheet may result in a non-approved payment period submission.

OTHER REPORTING TEMPLATES

OVERVIEW OF OTHER TEMPLATES

BHNNY has provided partners with reporting templates to easily report relevant data needed for applicable performance activities. BHNNY may require partners to provide additional documentation with due dates in addition to the final payment period due date as stated in the partner reporting templates and the Project Activity Schedule (Attachment A). Examples of these situations include:

- Quarterly submission of Patient Engagement Template
- Quarterly data reports
- Protocols for group visit model on June 30, 2017 and data report with the number of patients participating in group visits on March 31, 2018

Please refer to the Project Activity Schedule (Attachment A) for detailed description of supplemental documentation required for each performance activity. Each template should be saved using the naming convention that is listed in the "Style Guide" section.

PERFORMANCE ACTIVITIES

The templates to be used (if applicable) for performance activities are:

- Registry Template
- Patient Engagement Template
- Workforce Impact Analysis Template
- Training Template
- Root Cause Template
- Recruitment Needs Template
- Attestation

These templates can be accessed at http://www.albanymedpps.org/Finance.cfm in the additional documents section. The table on the following page details the requirements per performance activity that require a template provided by BHNNY. The “x” signifies that the identified template needs to be filled out and submitted to BHNNY PPS for that performance activity.

REGISTRY TEMPLATE AND PATIENT ENGAGEMENT TEMPLATE INSTRUCTIONS

There are multiple tabs in the Registry Template and Patient Engagement templates, both of which are labeled by the corresponding performance activity ID. You are only responsible for filling out the applicable tabs based on the projects and performance activities that are included in your Exhibit A and Partner Reporting Template. You may fill out all of the applicable tabs and save it as one document following the *Naming Convention* that is listed in the "Style Guide" section. The name of the document should be listed in the Partner Reporting Template under “Documentation File Name, if applicable” for **each** performance activity, the template will be used as supporting documentation. Additional examples can be found in the Project Activity Schedule (Attachment A).

There are some performance activities that require semi-annual or quarterly reporting. This can be found in the “Reporting Frequency” column in the table below. For each applicable performance activity, fill out the templates necessary for the applicable timeframe. All files should follow the naming convention previously provided in the “Style Guide” section of this guideline document. Then follow the *How to Log In and Upload Documentation to MOVEit* previously provided in the “Documentation Process” section to submit the documents. The Partner Reporting Template is not required to be included with these submissions.

Activity ID	Completion Date	Reporting Frequency	Reporting Date	Registry Template	Patient Engag. Template	Workforce Impact Analysis	Training Template	Other Templates
P_020	3/31/2017, 6/30/2017, 9/30/2017, 12/31/2017, 3/31/2018	Quarterly	4/10/2017, 7/10/2017, 10/10/2017, 1/10/2018, 4/10/2018			X		
B04_001	9/30/2017	One-time	10/10/2017					Recruitment Needs
B15_001	6/30/2017, 3/31/2018	Semi-annually	7/10/2017, 4/10/2018				X	
B15_002	3/31/2018	One-time	4/10/2018				X	
B03_007	3/31/2017, 6/30/2017, 9/30/2017, 12/31/2017, 3/31/2018	Quarterly	4/10/2017, 7/10/2017, 10/10/2017, 1/10/2018, 4/10/2018		X			
B02_006	3/31/2017, 6/30/2017, 9/30/2017, 12/31/2017, 3/31/2018	Quarterly	4/10/2017, 7/10/2017, 10/10/2017, 1/10/2018, 4/10/2018		X			
B09_007	3/31/2017, 6/30/2017, 9/30/2017, 12/31/2017, 3/31/2018	Quarterly	4/10/2017, 7/10/2017, 10/10/2017, 1/10/2018, 4/10/2018		X			
B10_007	3/31/2017, 6/30/2017, 9/30/2017, 12/31/2017, 3/31/2018	Quarterly	4/10/2017, 7/10/2017, 10/10/2017, 1/10/2018, 4/10/2018		X			
B13_003	3/31/2017, 6/30/2017, 9/30/2017, 12/31/2017, 3/31/2018	Quarterly	4/10/2017, 7/10/2017, 10/10/2017, 1/10/2018, 4/10/2018	X				
B13_004	3/31/2017, 6/30/2017, 9/30/2017, 12/31/2017, 3/31/2018	Quarterly	4/10/2017, 7/10/2017, 10/10/2017, 1/10/2018, 4/10/2018		X			
P_028	9/30/2017, 3/31/2018	Semi-annually	10/10/2017, 4/10/2018					Root Cause
B01_004	3/31/2017, 6/30/2017, 9/30/2017, 12/31/2017, 3/31/2018	Quarterly	4/10/2017, 7/10/2017, 10/10/2017, 1/10/2018, 4/10/2018		X			

B11_004	3/31/2017, 6/30/2017, 9/30/2017, 12/31/2017, 3/31/2018	Quarterly	4/10/2017, 7/10/2017, 10/10/2017, 1/10/2018, 4/10/2018		X			
P_021	3/31/2017, 6/30/2017, 9/30/2017, 12/31/2017, 3/31/2018	Quarterly	4/10/2017, 7/10/2017, 10/10/2017, 1/10/2018, 4/10/2018	X				
B11_003	3/31/2017, 6/30/2017, 9/30/2017, 12/31/2017, 3/31/2018	Quarterly	4/10/2017, 7/10/2017, 10/10/2017, 1/10/2018, 4/10/2018	X				
B10_006	3/31/2017, 6/30/2017, 9/30/2017, 12/31/2017, 3/31/2018	Quarterly	4/10/2017, 7/10/2017, 10/10/2017, 1/10/2018, 4/10/2018	X				

TRAINING TEMPLATE INSTRUCTIONS

All applicable sections of the training template must be filled out for each performance activity with a training template requirement. There are four tabs within each template:

1. Instructions
   - The Instructions tab is only informational and will be pre-populated with information specific to the applicable performance activity and training required for the completion of the performance activity.
2. Training
   - Columns B through G are pre-populated with the information that should be included in these columns per row for additional trainings.
   - Complete the **"Date of Training"** field and the **"Number of People Trained"** columns for any additional trainings that were held during the completion period.
3. Sign-In
   - The employee information should be copied from the “Roster” tab and pasted into the corresponding columns in the “Sign-In” tab.
   - Once populated with employee information, this tab should be printed out and provided to employees to sign-in at the applicable training session, or after an online training is completed. It is important to fill out all of the columns except the “Employee Signature” column prior to printing.
   - Do not add additional rows to the worksheet. If you need additional rows, complete and print an additional sign in sheet.
   - It is important that a designee attest that the staff on the sign-in sheet completed training by completing the bottom section after all employees have signed in and been trained.
   - If using multiple sign in sheets, ensure the attestations on all sheets are completed.
   - After the training, the sign-in sheet(s) should to be scanned into one PDF file and submitted as supporting documentation by the identified due date for that performance activity.
4. Roster
   - Include employee attendees’ name, title, NPI # (if applicable), and email on this tab.
   - This tab should be used to inform the Sign-In tab.

Once all appropriate rows have been completed in the “Training” and “Roster” tabs, save the template using the indicated naming convention. Submit this template with the PDF of all sign-in sheets combined.

WORKFORCE IMPACT ANALYSIS TEMPLATE INSTRUCTIONS

This template includes four (4) separate tabs. Only two (2) tabs must be completed by the partner: “Redeployed” and “New Hires”. The “RD Summary” and “NH Summary” tabs are locked and should not be edited. Additional guidance:

1. Redeployed
    - Fill out all of the columns in this tab, except columns R through T. Please do not edit any cells in columns R through T.
    - Some cells have drop down options. In these cells, select the appropriate response from the options listed.
    - When completing the columns for DSRIP titles, use the *DSRIP PPS Job Titles and Job Descriptions* document to select the title that most closely describes the employee’s position.
    - This tab will automatically populate the “RD Summary” tab.
2. New Hires
    - Fill out all of the applicable columns in this table
    - Some cells have drop down options. In these cells, select the appropriate response from the options listed.
    - This tab will automatically populate the “NH Summary” tab.

- The *DSRIP PPS Job Titles and Job Descriptions* document to use for the “Redeployed” tab can be accessed at http://www.albanymedpps.org/Finance.cfm in the additional documents section.
- The “New Hires” and “Redeployed” tabs will contain confidential information. Therefore, **only the “NH Summary” and “RD Summary” tabs should be submitted** to BHNNY PPS. These tabs should not be combined into one spreadsheet.
    - When all tabs have been completed, copy the “NH Summary” and “RD Summary” tabs into a new workbook by following the steps below:

1. Shft + Right Click on tabs to select both tabs

2. Select “Move or Copy” from the list

4. Select "new book" from sheets drop down menu

3. Select "Create a copy"

5. Click "OK"

- Once the new workbook is created with only these **two tabs**, save for upload using previously defined naming convention.
- For specific questions related to the Impact Analysis template, please review the FAQ document available at http://www.albanymedpps.org/Finance.cfm in the additional documents section.

QUESTIONS

Additional information and resources can be found at http://www.albanymedpps.org/Finance.cfm in the additional documents section.

Please contact BHNNY with any questions by emailing Chrissy McIntyre at McintyC@mail.amc.edu.

Please include "Phase II Partner Reporting Question" in the subject line.

Activity ID	Activity Type	Applicable Project or Outcome Measure	Activity Grouping	Bundle #, if applicable	Performance Activity	AMCH PPS Responsibility		PPS Responsibility Documents/ Recordings	Applicable Partner Service Type Summary	Supporting Documentation	Completion Date(s)	Reporting Date(s)	Payment Period
A03_001	IDS	2.a.i	Prerequisite		At least one representative from your organization must attend the quarterly PPS forum on February 15, 2017 and share lessons learned with meeting attendees. Representative will report back to staff at respective partner organization.	Host quarterly forum and share documents with attendees to bring back to their respective partner organizations.	WebEx Recording	Play recording (1 hr 49 min)	All	Proof of attendance via sign-in sheets or webinar sign-in; If you were unable to attend this meeting, review recorded presentation and submit an email attestation of completion	3/31/2017	4/10/2017	Period 1
A06_001	IDS	2.a.i	Prerequisite		Review and confirm all organizational contacts, committee memberships, and National Provider Identification (NPI) numbers assigned to organization.	Provide organizational distribution list, committee memberships, MOVEit users, and assigned NPIs and providers by March 17, 2017.	Organizational distribution list/ committee memberships, MOVEit users NPI Roster	Sent confidentially to primary and contract contacts via email 3/17 A_06 NPI Roster	All	Submit confirmation of review per AMCH PPS requirements	3/31/2017	4/10/2017	Period 1
A07_001	IDS	2.a.i	Prerequisite		Attend quarterly Cultural Competency/Health Literacy (CCHL) champion meetings between January 1, 2017 and March 31, 2017 to share best practices and network with other attendees.	Organize CCHL champion meetings to allow discussion and information sharing.	WebEx Recording	Play recording (1 hr 29 min)	All	Signed attendance sheet at CCHL champion meetings; If you were unable to attend this meeting, review recorded presentation and submit an email attestation of completion	3/31/2017	4/10/2017	Period 1
A11_001	Project Specific	2.a.v	Prerequisite		Attend monthly Medical Village Forums between January 1, 2017 and March 31, 2017. Must attend, at minimum, two out of the three meetings per quarter.	Host Medical Village forums.	January Meeting Recording (MP3) February Meeting Recording (MP3)	Please contact Simone Brooks, MBA BrooksS1@mail.amc.edu Please contact Simone Brooks, MBA BrooksS1@mail.amc.edu	Primary Care (adult, pedi, and family med); MH (outpatient); SNF; hospital (inpatient); SUD	Sign attendance sheet at Medical Village Forums or provide proof of attendance via webinar; If you were unable to attend this meeting, review recorded presentation and submit an email attestation of completion	3/31/2017	4/10/2017	Period 1
B02_001	Project Specific	3.a.i - M1	Bundle	B02 - BH/PC Integration - Model 1	Implement coordinated evidence-based care protocols including medication management and care engagement processes. Adopt CQAC-approved policy and guidelines.	Provide coordinated evidence-based care protocols and reasonable guidance, as requested.	Protocols	Clinical Practice Guideline ADHD Depression Diagnosis and Management of GAD & PD in adults Generalized Anxiety Disorder Macarthur Depression Toolkit USPSTF Depression Screening Guidelines for Adults	Primary Care (adult, pedi, and family med)	Meeting minutes detailing clinical approval to adopt evidence-based protocols	3/31/2017	4/10/2017	Period 1
B03_001	Project Specific	3.a.i - M3	Bundle	B03 - IMPACT Model	Coordinated evidence-based care protocols are in place, including a medication management and care engagement process to facilitate collaboration between the primary care physician and depression care manager. Policies and procedures include process for consulting with a Psychiatrist.	Provide reasonable guidance, as requested, on collaborating with a depression care manager and developing policies and procedures for consulting with a Psychiatrist.	Guidance Document(s)	AIMS Center Reference Sheet	Primary Care (adult, pedi, and family med)	Policy and procedures for collaborating with depression care manager and consulting with Psychiatrist	3/31/2017	4/10/2017	Period 1
B03_002	Project Specific	3.a.i - M3	Bundle	B03 - IMPACT Model	Employ a trained depression care manager that meets the requirements of the IMPACT model including coaching patients in behavioral activation, offering courses in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan.	Provide reasonable guidance, as requested, on the IMPACT model and requirements of depression care manager	Guidance Document(s)	AIMS Center Reference Sheet DCM JD AIMS Website Depression Care Manager Role Primary Care Provider and DCM	Primary Care (adult, pedi, and family med)	Job description and name of hired depression care manager; EMR screenshot demonstrating IMPACT interventions as defined in the performance activity	3/31/2017	4/10/2017	Period 1
B03_003	Project Specific	3.a.i - M3	Bundle	B03 - IMPACT Model	Designate a psychiatrist that meets the requirements of the IMPACT model. Develop protocols that meet IMPACT model requirements.	Provide reasonable guidance, as requested, on the IMPACT model and requirements of Psychiatrists.	Guidance Document(s)	AIMS Center Reference Sheet Applying the Integrated Care Approach Module 1 Information Applying the Integrated Care Approach Module 2 Information Psychiatric Consultant JD AIMS Website	Primary Care (adult, pedi, and family med)	Name of identified Psychiatrist(s); Protocols developed for follow-up care	3/31/2017	4/10/2017	Period 1
P_001	Outcome Measures Related	Potentially Preventable Readmissions ± (AHPP)	Stand Alone		Develop and implement protocols to provide discharge summaries to providers that will be responsible for follow-up care within 48-72 hours after discharge. Track providers that have been notified of required follow-up care after patient discharge.	Provide reasonable guidance, as requested, on developing protocols to provide discharge summaries to providers.		For assistance, please contact Karla Powers, MBA PowersK1@mail.amc.edu	Hospital (inpatient)	A report indicating the percentage of a sample of 50 inpatients discharged by March 31, 2017 whose follow-up providers have been sent the discharge summary	3/31/2017	4/10/2017	Period 1
P_002	Outcome Measures Related	Screening for Clinical Depression and Follow-up	Stand Alone		Adopt a standardized depression screening tool for people over 12 years old, approved by AMCH PPS, that is appropriate for patient population and: 1. Develop and implement protocols to ensure that all patients receive annual screening upon visit and document screening results in structured EMR field 2. Implement protocols to ensure that patients with a positive screening outcome receive follow-up care within 30 days	Provide examples of standardized screening tools that are acceptable for adoption. Provide reasonable guidance, as requested, for adoption of tool and minimum requirements for structured EMR fields to be used to capture screening results. Provide follow-up care requirements.	Standardized Screening Tools	Depression Diagnosis and Management of GAD & PD in adults Generalized Anxiety Disorder Macarthur Depression Toolkit USPSTF Depression Screening Guidelines for Adults MRR Clinical Depression Screening and follow up	Primary Care (adult, pedi, and family med); MH (outpatient)	Adopted standardized depression screening tool; Protocol to ensure patients with positive depression screening receive follow-up care within 30 days	3/31/2017	4/10/2017	Period 1
P_003	Outcome Measures Related	BH Outcome Measures	Stand Alone		Adopt a standardized developmental and autism screening tool for children, approved by AMCH PPS, that is appropriate for patient population and: 1. Develop and implement protocols to ensure that patients receive screening at 18 months and 24 months of age, and document screening results in structured EMR field 2. Implement protocols to ensure that patients with a positive screening outcome receive appropriate follow-up care	Provide examples of standardized screening tools that are acceptable for adoption. Provide reasonable guidance, as requested, for adoption of tool and minimum requirements for structured EMR fields to be used to capture screening results. Provide follow-up care requirements.	Standardized Screening Tools	Clinical Practice Guideline ADHD M-CHAT-R_F P_003 Attestation Form	Primary Care (pedi and family med)	Attestation that standardized screening tool has been adopted and protocols to ensure patients with positive screening receive appropriate follow-up care have been implemented	3/31/2017	4/10/2017	Period 1
P_004	Project Specific	3.a.ii	Stand Alone		Develop a proposal and business plan that addresses the minimum requirements of the crisis stabilization project (Project 3.a.ii) provided by AMCH PPS and demonstrates ability to meet these minimum requirements. Proposal and business plan must be submitted to AMCH PPS no later than March 31, 2017.	Provide minimum requirements and reasonable guidance, as requested, for development of proposal and business plan.	Guidance Document(s)	BHNNY DSRIP Project Summary 3aii Crisis Stabilization Project Proposal Template Proposal Criteria_3.a.ii	MH (outpatient); Inpatient & Emergency Behavioral Health Services; SUD; Community Based Residential Facility (MH)	Proposal and business plan that meet AMCH PPS minimum requirements for crisis stabilization project (project 3.a.ii) requirements	3/31/2017	4/10/2017	Period 1
P_006	Project Specific IDS	2.d.i 2.a.i	Stand Alone		Adopt and implement Client Complaint and Grievance Policy provided by AMCH PPS.	Provide Client Complaint and Grievance Policy.	BHNNY Client Grievance Policy	BHNNY Client Grievance Policy	All	Protocols developed to adopt and implement Client Complaint and Grievance Policy	3/31/2017 6/30/2017	4/10/2017 7/10/2017	Period 1 Period 2
P_007	IDS	2.a.i	Stand Alone		Complete all Phase II contracting Performance Activities for Payment Period 1 in accordance with instructions provided by AMCH PPS by the due date specified.	Track satisfactory completion of Performance Activities.		To be sent confidentially to organizations week of 4/3	All	Completed reporting template(s) and all required supporting documentation, for each reporting period within AMCH PPS established timeframes, are required to consider metric achievement completed	3/31/2017	4/10/2017	Period 1

Activity ID	Activity Type	Applicable Project or Outcome Measure	Activity Grouping	Bundle #, if applicable	Performance Activity	AMCH PPS Responsibility		PPS Responsibility Documents/ Recordings	Applicable Partner Service Type Summary	Supporting Documentation	Completion Date(s)	Reporting Date(s)	Payment Period
A02_001	IDS	2.a.i	Prerequisite		DSRIP Hixny QE Agreement and One-To-One Exchange Agreement has been signed and connectivity has been established with Hixny (RHIO) that meets minimum requirements as defined by Hixny.	Facilitate engagement with Hixny and monitor provider progress. Provide minimum requirements for Hixny connectivity.			All RHIO eligible organizations	Copy of signed QE Agreement and One-To-One Exchange Agreement; Evidence of ongoing work with Hixny via progress updates with AMCH PPS PMO	9/30/2017	10/10/2017	Period 2
A03_002	IDS	2.a.i	Prerequisite		At least one representative from your organization must attend the quarterly PPS forum between April 1, 2017 and September 30, 2017 and share lessons learned with meeting attendees. Representative will report back to staff at respective partner organization.	Host quarterly forum and share documents with attendees to bring back to their respective partner organizations.			All	Proof of attendance via sign-in sheets or webinar sign-in; If you were unable to attend this meeting, review recorded presentation and submit an email attestation of completion	6/30/2017, 9/30/2017	7/10/2017, 10/10/2017	Period 2
A04_001	IDS	2.a.i	Prerequisite		Complete annual Financial Sustainability Survey.	Provide survey and guidance on survey completion to partners.			All	Submission of completed Financial Sustainability Survey	9/30/2017	10/10/2017	Period 2
A05_001	IDS	2.a.i	Prerequisite		Attend all required VBP education sessions between April 1, 2017 and September 30, 2017 for applicable provider type as defined by AMCH PPS.	Host VBP education sessions and define required sessions per provider type.			All	Attend and sign-in at required VBP sessions	9/30/2017	10/10/2017	Period 2
A06_002	IDS	2.a.i	Prerequisite		Review and confirm all organizational contacts, committee memberships, and National Provider Identification (NPI) numbers assigned to organization.	Provide organizational distribution list, committee memberships, MOVEit users, and assigned NPIs and providers.			All	Submit confirmation of review per AMCH PPS requirements	9/30/2017	10/10/2017	Period 2
A07_002	IDS	2.a.i	Prerequisite		Attend quarterly Cultural Competency/Health Literacy (CCHL) champion meetings between April 1, 2017 and September 30, 2017 to share best practices and network with other attendees.	Organize CCHL champion meetings to allow discussion and information sharing.			All	Signed attendance sheet at CCHL champion meetings; If you were unable to attend this meeting, review recorded presentation and submit an email attestation of completion	6/30/2017, 9/30/2017	7/10/2017, 10/10/2017	Period 2
A08_001	Project Specific	3.a.i - M1	Prerequisite		Have a licensed behavioral health provider available onsite eight hours per week by June 30, 2017 at the minimum number of sites as defined by AMCH PPS.	Provide reasonable guidance, as requested, on integrating behavioral health services at primary care locations. Provide data requirements for supporting documentation. Provide requirements for minimum number of sites.			Primary Care (adult, pedi, and family med)	Provide name(s) of behavioral health provider(s) available onsite by June 30, 2017 and any additional information (hire date, license number, availability, etc.) as defined by ACMH PPS	6/30/2017	7/10/2017	Period 2
A09_001	Project Specific	3.a.i - all models	Prerequisite		Identified clinical representative attends at least 80% of all applicable AMCH PPS BH meetings held between April 1, 2017 and September 30, 2017.	Provide meeting information and guidance on the appropriate staff attendance.			Primary Care (adult, pedi, and family med); MH (outpatient); SUD	Sign attendance sheet at all AMCH PPS BH relevant meetings or provide proof of attendance via webinar	9/30/2017	10/10/2017	Period 2
A10_001	Project Specific	3.a.i - M2	Prerequisite		Have a primary care provider (PCPs, or NPs or PAs working closely with a PCP) available onsite eight hours per week by June 30, 2017.	Provide reasonable guidance, as requested, on integrating primary care services at behavioral health locations. Provide data requirements for supporting documentation.			MH (outpatient Rx only); SUD	Provide name(s) of primary care provider(s) available onsite by June 2017 and any additional information (hire date, license number, availability, etc.) as defined by ACMH PPS	6/30/2017	7/10/2017	Period 2
A11_002	Project Specific	2.a.v	Prerequisite		Attend monthly Medical Village Forums between April 1, 2017 and September 30, 2017. Must attend, at minimum, two out of the three meetings per quarter.	Host Medical Village forums.			Primary Care (adult, pedi, and family med); MH (outpatient); SNF; hospital (inpatient); SUD	Sign attendance sheet at Medical Village Forums or provide proof of attendance via webinar; If you were unable to attend this meeting, review recorded presentation and submit an email attestation of completion	6/30/2017, 9/30/2017	7/10/2017, 10/10/2017	Period 2
B01_001	IDS	2.a.i	Bundle	B01 - Health Home at Risk	Establish an agreement with at least one social services organization to provide support to patients that meet patient needs. Establish a referral process and information sharing protocols.	Provide reasonable guidance and support, as requested, to identify appropriate social services agencies and develop formalized partnerships.			Primary Care (adult, pedi, and family med)	Formal agreement/contract with social services organization; Referral process; Information sharing protocols	6/30/2017	7/10/2017	Period 2
B01_002	IDS	2.a.i	Bundle	B01 - Health Home at Risk	Provide formal tobacco cessation education to identified patients or develop a process to refer identified patients to a community educator, home-based support or other appropriate community resource for tobacco cessation.	Provide reasonable guidance and support, as requested, on appropriate tobacco cessation best practices and protocols. Provide support to identify appropriate community based organizations that provide tobacco cessation education when not provided at organization.			Primary Care (adult, pedi, and family med); SUD	Protocols developed to provide formal tobacco cessation education or to refer identified patients to community educator	6/30/2017	7/10/2017	Period 2
B01_003	IDS	2.a.i	Bundle	B01 - Health Home at Risk	Establish an agreement with a health home care management agency and develop a referral process to the health home care management agency for patients identified as health home at-risk.	Provide reasonable guidelines and support, as requested, for developing agreement and referral process to Health Home Care Management Agency.			Primary Care (adult, pedi, and family med)	Total number of patients referred to health home care management agency; Copy of agreement with health home care management agency	6/30/2017	7/10/2017	Period 2
B02_002	Project Specific	3.a.i - M1	Bundle	B02 - BH/PC Integration - Model 1	Demonstrate the integration of medical and behavioral health records in the EMR according to minimum requirements provided by AMCH PPS. Ensure all applicable staff has access to view prescribed medications.	Provide minimum requirements for integration of medical and behavioral health records in EMR.			Primary Care (adult, pedi, and family med)	Screenshot of de-identified medical records and behavioral health records in the EMR that meet minimum requirements provided by AMCH PPS	6/30/2017	7/10/2017	Period 2
B02_003	Project Specific	3.a.i - M1	Bundle	B02 - BH/PC Integration - Model 1	Demonstrate progress on integrating behavioral health into primary care by: 1. Completing readiness assessment using United Hospital Fund/Montefiore Health System's Continuum-Based Framework 2. Developing an integration workplan using United Hospital Fund/Montefiore Health System's Continuum-Based Framework as a guide	Provide United Hospital Fund/Montefiore Health System's Continuum-Based Framework and assessment to partners, and provide reasonable guidance, as requested, on development of integration plan.			Primary Care (adult, pedi, and family med)	Completed United Hospital Fund/Montefiore Health System's Continuum-Based Framework readiness assessment and results; Integration plan	6/30/2017	7/10/2017	Period 2
B02_004	Project Specific	3.a.i - M1	Bundle	B02 - BH/PC Integration - Model 1	Develop and implement protocols for "warm transfers" to a behavioral health provider or care team member that will link patient to appropriate behavioral health provider for positive depression, behavioral, developmental, and/or autism screenings and document in EMR using structured fields and complete templates as defined by AMCH PPS. Train identified staff on protocols for "warm transfers".	Provide recommendations for structured fields and templates in EMR for partners to track positive depression screenings that result in a "warm transfer."			Primary Care (adult, pedi, and family med)	Screenshots of notation in EMR proving that "warm transfer" has occurred; Sign-in sheets with training dates for staff that received training on protocols for "warm transfers"	9/30/2017	10/10/2017	Period 2
B03_004	Project Specific	3.a.i - M3	Bundle	B03 - IMPACT Model	Demonstrate the integration of medical and behavioral health records in the EMR according to minimum requirements provided by AMCH PPS. Ensure all applicable staff has access to view prescribed medications.	Provide minimum requirements for integration of medical and behavioral health records in the EMR.			Primary Care (adult, pedi, and family med)	Screenshot of de-identified medical records and behavioral health records in the EMR that meet minimum requirements provided by AMCH PPS	6/30/2017	7/10/2017	Period 2
B03_005	Project Specific	3.a.i - M3	Bundle	B03 - IMPACT Model	Adopt University of Washington (UW) registry, or other AMCH PPS approved patient registry, to track patients that are receiving care from providers who adopted the IMPACT Model.	Provide reasonable guidance, as requested, on adoption of UW registry or other AMCH PPS approved registry. Provide data specifications for submission of registry data.			Primary Care (adult, pedi, and family med)	Submit registry data that meets AMCH PPS minimum requirements for timeframe of January 1, 2017 to May 31, 2017	6/30/2017	7/10/2017	Period 2
B03_006	Project Specific	3.a.i - M3	Bundle	B03 - IMPACT Model	Provide "stepped care" as required by the IMPACT model that includes an algorithm to evaluate patients 10 -12 weeks after start of treatment plan.	Provide reasonable guidance, as requested, on the IMPACT model and evidence-based algorithm.			Primary Care (adult, pedi, and family med)	Proof that evidence-based practice guidelines for "stepped care" that meet the IMPACT model requirements have been adopted and implemented	9/30/2017	10/10/2017	Period 2
B04_001	IDS	2.a.i	Bundle	B04 - Assessments	Complete recruitment needs assessment using AMCH PPS provided template.	Provide recruitment needs assessment template and guidance for completion.			All	Completed recruitment needs assessment template	9/30/2017	10/10/2017	Period 2
B04_002	IDS	2.a.i	Bundle	B04 - Assessments	Complete Current State Assessment survey.	Provide Current State Assessment survey.			All	Submit completed Current State Assessment survey	9/30/2017	10/10/2017	Period 2
B05_001	Project Specific	2.a.v	Bundle	B05 - Medical Village	Develop a business plan that addresses gaps identified in Community Needs Assessment and includes all of the components required by AMCH PPS.	Provide Community Needs Assessment and the gaps in care that were identified through the assessment. Provide requirements of the business plan.			SNF	Business plan that includes all of the requirements of AMCH PPS	6/30/2017	7/10/2017	Period 2

Activity ID	Activity Type	Applicable Project or Outcome Measure	Activity Grouping	Bundle #, if applicable	Performance Activity	AMCH PPS Responsibility		PPS Responsibility Documents/ Recordings	Applicable Partner Service Type Summary	Supporting Documentation	Completion Date(s)	Reporting Date(s)	Payment Period
B05_002	Project Specific	2.a.v	Bundle	B05 - Medical Village	Provide a list of new services that are now being provided to address gaps in the Community Needs Assessment as outlined in business plan submitted to AMCH PPS.	Provide Community Needs Assessment and the gaps in care that were identified through the assessment.			SNF	List of new services and the protocols to implement these new services	9/30/2017	10/10/2017	Period 2
B06_001	Outcome Measures Related	Diabetes Monitoring for People with Diabetes and Schizophrenia (AHPP)/ Diabetes Screening for People with Schizophrenia or Bipolar Disease who are Using Antipsychotic Medication	Bundle	B06 - Diabetes Monitoring with BH	Provide baseline report that meets AMCH PPS data specifications for any three consecutive, complete months of data between January 2017 to June 2017 for: 1. Patients (ages 18-64) with schizophrenia or bipolar disease who were dispensed an antipsychotic medication and have been screened for diabetes 2. Patients (ages 18-64) with diabetes and schizophrenia that have received both, HbA1C and LDL-C screenings Data must be captured in structured fields in the EMR.	Provide data specifications for baseline report. Provide specifications and requirements for structured data fields in the EMR.			Primary Care (adult and family med); MH (outpatient Rx only)	Baseline report that meets AMCH PPS data specifications	6/30/2017	7/10/2017	Period 2
B06_002	Outcome Measures Related	Diabetes Monitoring for People with Diabetes and Schizophrenia (AHPP)	Bundle	B06 - Diabetes Monitoring with BH	Develop and implement protocols to identify patients with diabetes and schizophrenia that are due for HbA1C and/or LDL-C tests and reach out to ensure tests are completed in a timely manner according to evidence-based guidelines and best practices. Create EMR alerts or a process to remind clinical staff that HbA1C and/or LDL-C tests are required and pending for identified patients.	Provide reasonable guidance and support, as requested, on best practices to identify patients missing appropriate diabetes monitoring tests and ensure appropriate follow-up. Provide reasonable guidance, as requested, for development of EMR alerts for pending HbA1C and LDL-C tests. Provide data specifications for data submission.			Primary Care (adult and family med); MH (outpatient Rx only)	Provide the number of patients with diabetes and schizophrenia that were due for HbA1C and/or LDL-C tests, and the number of those patients that were contacted to bring into care between April 1, 2017 to September 30, 2017; Screenshot of EMR alert in place or a process in place to remind clinical staff that HbA1C and/or LDL-C tests are required and pending for identified patients	9/30/2017	10/10/2017	Period 2
B06_003	Outcome Measures Related	Diabetes Screening for People with Schizophrenia or Bipolar Disease who are Using Antipsychotic Medication	Bundle	B06 - Diabetes Monitoring with BH	Develop and implement protocols to identify patients with schizophrenia or bipolar disease who are using antipsychotic medication that have not been screened for diabetes and ensure screening is completed upon next visit. Create EMR alerts or a process to remind clinical staff that diabetes screenings are required and pending for identified patients.	Provide reasonable guidance and support, as requested, on protocols to identify patients with schizophrenia or bipolar disease that have not been screened for diabetes and ensure screening is completed upon next visit. Provide data specifications for data submission.			Primary Care (adult and family med); MH (outpatient Rx only)	Provide the number of schizophrenia or bipolar disease patients who are using antipsychotic medication that have not been screened for diabetes, and of those patients, the number that completed screening upon their next visit	9/30/2017	10/10/2017	Period 2
B06_004	Outcome Measures Related	Diabetes Monitoring for People with Diabetes and Schizophrenia (AHPP)	Bundle	B06 - Diabetes Monitoring with BH	Develop a process for clinicians to use Hixny to look up latest HbA1C and LDL-C test results, from any provider that has seen a patient with diabetes and schizophrenia, and incorporate into decision making process during visit.	Provide reasonable guidance, as requested, for use of Hixny to review test results across different providers that may have seen a patient.			Primary Care (adult and family med); MH (outpatient Rx only)	De-identified screen shot that demonstrates provider can view lab values in Hixny	9/30/2017	10/10/2017	Period 2
B07_001	Outcome Measures Related	Smoking Cessation Measures	Bundle	B07 - Smoking Cessation	Demonstrate the ability to prompt providers to complete the 5 A's of tobacco control in the EMR. Develop and implement a workflow that ensures providers are completing the 5 A's of tobacco control for all applicable patients. Provide training to staff to incorporate the workflow for completion and documentation of the 5 A's of tobacco control.	Provide reasonable guidance, as requested, to ensure providers are completing the 5 A's of tobacco control for all applicable patients and tracking in EMR.			Primary Care (adult, pedi, family med)	Provide de-identified screenshots demonstrating the completion of the 5 A's of tobacco control for 10 unique patients, or the maximum number of patients that are eligible; Training materials (including practice protocols), dates, and sign-in sheets	6/30/2017	7/10/2017	Period 2
B07_002	Outcome Measures Related	Smoking Cessation Measures	Bundle	B07 - Smoking Cessation	Develop a process to refer identified patients to NYS Smoker's Quit line according to evidence-based guidelines. Implement a process and refer identified patients to quit line.	Provide information on the NYS Smoker's Quit line and evidence-based guidelines.			Primary Care (adult, pedi, family med)	Process developed to refer to NYS Smoker's Quit line; Roster of 10 unique patients that were referred to quit line following referral process	6/30/2017	7/10/2017	Period 2
B08_001	Outcome Measures Related	Asthma Measures	Bundle	B08 - Asthma Related ED/Inpatient Visits	Develop and implement protocols that ensure providers are prescribing preferred formulary asthma controller medications to persistent and poorly controlled asthmatics upon discharge from ED or hospitalization when applicable.	Provide reasonable guidance and support, as requested, on acceptable formulary asthma controller medications for identified patients per accepted definitions. Provide guidance on development of appropriate processes and protocols upon discharge. Provide data specifications for requested data submissions.			Hospital (ED and inpatient)	Provide percent of patients that were discharged with controller prescriptions according to AMCH PPS data specifications	6/30/2017	7/10/2017	Period 2
B08_002	Outcome Measures Related	Asthma Measures	Bundle	B08 - Asthma Related ED/Inpatient Visits	Adopt and implement minimum requirements of asthma pathways best practice guidelines in the emergency department as defined by AMCH PPS.	Provide reasonable guidance, as requested, and define minimum requirements for asthma pathways best practices to be adopted in the ED.			Hospital (ED)	Protocols developed to implement best practice guidelines	6/30/2017	7/10/2017	Period 2
B08_003	Outcome Measures Related	Asthma Measures	Bundle	B08 - Asthma Related ED/Inpatient Visits	Adopt and implement protocols to refer persistent and poorly controlled asthmatics to home-based intervention services upon discharge from ED or inpatient stay.	Provide reasonable guidance, as requested, for development of appropriate protocols.			Hospital (ED and inpatient)	Protocols developed to refer persistent and poorly controlled asthmatics to home-based intervention services	9/30/2017	10/10/2017	Period 2
B09_001	Project Specific	3.a.i - M2	Bundle	B09 - BH/PC Integration - Model 2	Demonstrate the integration of medical and behavioral health records in the EMR according to minimum requirements provided by AMCH PPS. Ensure all applicable staff has access to view prescribed medications.	Provide minimum requirements for integration of medical and behavioral health records in the EMR.			MH (outpatient Rx only); SUD	Screenshot of de-identified medical records and behavioral health records in the EMR that meet minimum requirements provided by AMCH PPS	6/30/2017	7/10/2017	Period 2
B09_002	Project Specific	3.a.i - M2	Bundle	B09 - BH/PC Integration - Model 2	Implement monthly interdisciplinary team huddles to review current list of patients and ongoing development of team approach.	Provide guidelines and requirements for interdisciplinary team huddles.			MH (outpatient Rx only); SUD	Dates and times of monthly team huddles, attendees, and topics discussed	6/30/2017	7/10/2017	Period 2
B09_003	Project Specific	3.a.i - M2	Bundle	B09 - BH/PC Integration - Model 2	Develop and implement protocols for "warm transfers" to a primary care provider or care team member that will link patient to appropriate primary care provider for any positive preventive screening results and document in EMR using structured fields and templates as defined by AMCH PPS. Train identified staff on protocols for "warm transfers."	Provide recommendations for structured fields and templates in EMR for partners to track preventive care screenings that result in a "warm transfer" from primary care provider.			MH (outpatient Rx only); SUD	Screenshots of notation in EMR proving that "warm transfer" has occurred; Sign-in sheets with training dates for staff that received training on protocols for "warm transfers"	9/30/2017	10/10/2017	Period 2
B09_004	Project Specific	3.a.i - M2	Bundle	B09 - BH/PC Integration - Model 2	Develop and implement protocols to ensure that all patients receive preventive care screenings using appropriate tools and applicable CPT codes as identified by AMCH PPS. Demonstrate that screenings have been documented in a structured field in EMR and train identified staff on appropriate documentation of screenings in EMR.	Provide examples of acceptable primary care services, CPT codes and tools; Provide minimum requirements for structured EMR fields to be used to capture screenings			MH (outpatient Rx only); SUD	Protocols developed to ensure patients receive preventive care screenings; Screenshot of EMR with structured fields for documentation of preventive care screenings; Training dates and sign-in sheets for all identified staff	9/30/2017	10/10/2017	Period 2
B09_005	Project Specific	3.a.i - M2	Bundle	B09 - BH/PC Integration - Model 2	Implement coordinated evidence-based care protocols including medication management and care engagement processes. Adopt CQAC-approved policies and guidelines.	Provide coordinated evidence based care protocols and reasonable guidance, as requested.			MH (outpatient Rx only); SUD	Documentation detailing how the evidence-based protocols were adopted	9/30/2017	10/10/2017	Period 2
B10_001	Project Specific	3.b.i	Bundle	B10 - CVD/HTN Management	Adopt and follow standardized treatment protocols that align with national guidelines for hypertension and elevated cholesterol. Train identified staff on protocols.	Provide best-practice guidelines for medication therapy and elevated cholesterol management.			Primary Care (adult and family med)	Protocols that have been adopted; Signed attestations from clinicians after guideline review	6/30/2017	7/10/2017	Period 2
B10_002	Project Specific	3.b.i	Bundle	B10 - CVD/HTN Management	Demonstrate that once-daily regimens or fixed combination pills are prescribed when appropriate.	Provide reasonable guidance and support, as requested, on prescribing once-daily regimens or fixed combination pills when appropriate.			Primary Care (adult and family med)	De-identified screenshot of prescribed regimens captured in the EMR	6/30/2017	7/10/2017	Period 2
B10_003	Project Specific	3.b.i	Bundle	B10 - CVD/HTN Management	Develop care coordination teams to include nursing staff, pharmacists, dieticians, and CHW's to address lifestyle changes, medication adherence, health literacy issues, patient self efficacy and confidence in self-management for HTN patients. Establish a huddle timeline and hold team huddles according to team timeline. Huddle timeline must include, at a minimum, a monthly huddle.	Provide reasonable guidance, as requested, and support on care coordination team membership and examples of huddle process.			Primary Care (adult and family med)	Schedule of huddle meetings and items discussed at meetings	6/30/2017	7/10/2017	Period 2

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B10_004	Project Specific	3.b.i	Bundle	B10 - CVD/HTN Management	Develop and implement protocols for home blood pressure monitoring with follow-up support including equipment evaluation and follow-up if blood pressure results are abnormal.	Provide best practice guidelines for home blood pressure monitoring.			Primary Care (adult and family med)	Protocols developed for home blood pressure monitoring with follow-up support	9/30/2017	10/10/2017	Period 2
B11_001	Outcome Measures Related	Potentially Preventable Emergency Room Visits ± (AHPP)	Bundle	B11 - ED Utilization	Incorporate provisions to patient education on appropriate emergency department use, and alternative resources within close proximity, that meets the minimum requirements of AMCH PPS.	Provide patient education tools in English and Spanish that include locations for alternative options. Provide minimum requirements for other tools for patient education.			ED; Primary Care (adult, pedi, and family med); CM; MH (outpatient); Urgent Care; Outpatient Specialty Care	Attestation that patient education tool that meets minimum requirements of AMCH PPS has been implemented	6/30/2017	7/10/2017	Period 2
B11_002	Outcome Measures Related	Potentially Preventable Emergency Room Visits ± (AHPP)	Bundle	B11 - ED Utilization	Identify individual(s) that will provide patient navigator services as defined by AMCH PPS. Adopt and implement emergency department process flow to include patient triage, referral, patient review and assessment as defined by AMCH PPS. Track all patient navigation services provided by organization.	Provide minimum requirements for patient navigator services.			ED	List of patient navigation services offered by organization; Roster of identified individual(s) that provide patient navigation services	9/30/2017	10/10/2017	Period 2
B12_001	Outcome Measures Related	Controlling High Blood Pressure	Bundle	B12 - High Blood Pressure Monitoring	Develop protocols and appropriate tools to identify and proactively reach out to patients with the following conditions to bring them in for care : 1. Two or more elevated blood pressure readings in the past year with no diagnosis of hypertension 2. An abnormal blood pressure reading as defined by AMCH PPS without a visit in the past six months 3. Diagnosis of hypertension without a visit in the past six months Provide training to staff to ensure effective patient identification and appropriate visit scheduling.	Provide reasonable guidance, as requested, on tools and best-practices to identify patients at risk for hypertension and outreach initiatives, Provide data specifications for data submission and define abnormal blood pressure for protocol development.			Primary Care (adult and family med)	Protocols developed to identify patients at risk and reach out to bring them in for care; Provide total number of patients that were identified as at-risk and those successfully brought in for care	6/30/2017	7/10/2017	Period 2
B13_001	Outcome Measures Related	Asthma Measures	Bundle	B13 - Poorly Controlled Asthma	Develop and adopt protocols that ensure providers are prescribing preferred formulary asthma controller medications to persistent and poorly controlled asthmatic patients. Track rate of asthma controller medications prescribed to persistent and poorly controlled asthmatics and provide data for at least three consecutive, complete months between January 2017 to June 2017 to develop baseline.	Provide guidance and support, as requested, on acceptable formulary asthma controller medications for identified patients per accepted definitions. Provide guidance on development of appropriate processes and protocols. Provide data specifications for data submission			Primary Care (adult, pedi, and family med); Specialists (pulmonologists/allergists)	Provide baseline rate of asthma controller medications, prescribed to persistent and poorly controlled asthmatics for at least three consecutive, complete months from January 2017 to June 2017, that meets AMCH PPS data specifications	6/30/2017	7/10/2017	Period 2
B14_001	Outcome Measures Related	Asthma Measures	Bundle	B14 - Asthma Control Assessment	Implement a standardized asthma control assessment tool such as Asthma Control Test (ACT) and track rate data for at least three consecutive, complete months between March 2017 to September 2017 to develop baseline for improvement purposes.	Provide requirements and best practices for standardized asthma control assessment tool such as the Asthma Control Test (ACT). Provide data specifications for data submission.			Primary Care (adult, pedi, and family med), Specialists (pulmonologists/allergist)	Baseline report including the rate of standardized asthma control rate	9/30/2017	10/10/2017	Period 2
P_005	IDS	2.a.i	Stand Alone		Establish an agreement with at least one health home care management agency for care management services and develop information sharing protocols.	Provide reasonable guidance and support, as requested, to identify appropriate health home care management agencies and develop formalized partnerships.			Primary Care (adult, pedi, and family med); MH (outpatient)	Formal agreement/contract with a health home care management agency; Referral process and information sharing protocols	6/30/2017	7/10/2017	Period 2
P_008	IDS	2.a.i	Stand Alone		Adopt the evidence-based health literacy screening tool provided by AMCH PPS and develop protocols to implement into daily practice.	Provide evidence-based health literacy screening tool and reasonable guidance, as requested, for implementation into daily practice.			All	10 de-identified screenshots of screening tool results, or report of number of patients that received screening and screening results if EMR not available	6/30/2017	7/10/2017	Period 2
P_009	Outcome Measures Related	Screening for Clinical Depression and Follow-up	Stand Alone		Provide report for: 1. Percent of patients screened for clinical depression using a standardized screening tool approved by AMCH PPS 2. Percent of patients with positive depression screening that received follow-up care within 30 days after positive screening Collect data for at least three consecutive, complete months between January 2017 and June 2017 to develop a baseline. Data must be captured in EMR using structured fields as defined by AMCH PPS.	Define structured fields and report format to track the number of patients that screened positive for depression and received follow-up care within 30 days after a positive screening; Provide list of eligible events that qualify as follow-up care.			Primary Care (adult, pedi, and family med); MH (outpatient); SUD	Data report that meets AMCH PPS required format	6/30/2017	7/10/2017	Period 2
P_010	Outcome Measures Related	Potentially Preventable Readmissions ± (AHPP)	Stand Alone		Develop protocols to adopt and implement the LACE Index Scoring Tool and ensure that the LACE score is shared with appropriate primary care and specialty care providers post discharge. Include discharge planning and transitions of care actions, follow-up coordination including transmission of discharge summaries within 48-72 hours, patient education and care plan development for patients with LACE score of 10 or greater.	Provide LACE Index Scoring Tool and guidance, as requested. Provide guidelines for minimum requirements based on LACE score.			ED; Hospital (inpatient)	Updated transitions of care protocols that include use of LACE Index Score as a guide for transitions of care activities that include early discharge planning, follow-up coordination, patient education, care plan development, and identifying appropriate community linkages; Roster of patients with a LACE score higher than 10 for all patients available since implementation between April 1, 2017 to September 30, 2017	9/30/2017	10/10/2017	Period 2
P_011	IDS	2.a.i	Stand Alone		Bi-directional Hixny (RHIO) connectivity has been established and is maintained per standards as defined by AMCH PPS.	Provide reasonable guidance, as requested, and standards in establishing bi-directional connectivity to Hixny.			All RHIO eligible organizations	Agreement with Hixny for bi-directional connectivity; De-identified evidence of clinical data submission to Hixny	9/30/2017	10/10/2017	Period 2
P_012	IDS	2.a.i	Stand Alone		Subscribe to Hixny (RHIO) event notifications to receive discharge alerts and summary documents via RHIO. Develop protocols to follow up with patients discharged from hospital within 48-72 hours of discharge.	Provide reasonable guidance and support, as requested, in establishing event notifications via Hixny. Provide minimum requirements for protocols to be developed for patient follow-up within 48-72 hours of discharge.			All RHIO eligible organizations	Agreement with Hixny for event notifications; Protocols to be followed upon receipt of alerts/discharge summary; Sample of five de-identified screenshots documenting receipt of alerts	9/30/2017	10/10/2017	Period 2
P_013	IDS	2.a.i	Stand Alone		Adopt and implement CG-CAHPS patient experience survey and administer to patients, including uninsured population, using the guidelines set by AMCH PPS. Submit at least three consecutive, complete months of data between January 2017 to September 2017 to develop baseline.	Provide guidance, as requested, on adoption of CG-CAHPS patient experience survey. Provide data specifications for data submission.			Primary Care (adult, pedi, and family med)	Provide at least three consecutive, complete months of patient experience data according to AMCH PPS data specifications	9/30/2017	10/10/2017	Period 2
P_014	Outcome Measures Related	Screening for Clinical Depression and Follow-up	Stand Alone		Ensure EMR has capability to flag patients that have not been screened for clinical depression, using a standardized depression screening tool approved by AMCH PPS, within the last year and alert staff to provide screening upon patient's next visit. Revise protocols to incorporate these alerts and ensure all key staff are appropriately trained on updated protocols.	Provide reasonable guidance, as requested, to partners on structured fields to flag patients and alert staff in EMR.			Primary Care (adult, pedi, and family med); MH (outpatient); SUD	Five de-identified screenshots of alert in EMR for patients that have not been screened for clinical depression using a standardized depression screening tool within the last year	9/30/2017	10/10/2017	Period 2
P_015	IDS	2.a.i	Stand Alone		Develop a comprehensive medication reconciliation process and incorporate process as part of every visit for patients, as applicable.	Provide reasonable guidance, as requested, on medication reconciliation processes.			Primary Care (adult, pedi, and family med); MH (outpatient); Hospital (inpatient, psych, ED)	Medication reconciliation process developed to occur during every applicable visit	9/30/2017	10/10/2017	Period 2
P_016	Outcome Measures Related	Statin Therapy for Patients with Cardiovascular Disease	Stand Alone		Develop and implement a process to: 1. Identify patients that are eligible for at least one high- or moderate-intensity statin therapy based on HEDIS criteria 2. Educate and counsel eligible patients on benefits of high- or moderate-intensity statin therapy 3. Prescribe high- or moderate-intensity statin therapy medications to eligible patients 4. Track patients prescribed at least one high- or moderate-intensity statin therapy and proactively reach out to those that are overdue for prescription refill to ensure medication adherence Track all steps in EMR structured fields/templates.	Provide reasonable guidance and technical assistance, as requested, on high- or moderate-intensity statin therapy.			Primary Care (adult and family med); Outpatient Specialty (cardiologist)	Provide evidence that patients prescribed at least one high- or moderate-intensity statin therapy are being tracked and appropriate outreach is occurring	9/30/2017	10/10/2017	Period 2

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P_017	Outcome Measures Related	Asthma Measures	Stand Alone		Develop and implement protocols to ensure that identified asthma patients are filling prescriptions within two weeks of discharge via case manager referrals, direct calls from care coordinator, ED navigators or other identified methods as deemed appropriate by AMCH PPS. Gather baseline data to identify root causes for patients' inability to fill medications within two weeks.	Provide definition for asthma patients that need to be tracked for filled prescriptions within two weeks of discharge from ED. Provide reasonable guidance, as requested, on appropriate follow-up protocols and root cause analysis protocols.			Hospital (ED and inpatient)	One example of completed root cause analysis; Provide total number of patients contacted after discharge	9/30/2017	10/10/2017	Period 2
P_018	Outcome Measures Related	Asthma Measures	Stand Alone		Form co-management agreements with asthma specialists and asthma educators to provide a framework for better communication and safe transition of care, as well as optimal health care, consistent with national guidelines for asthma patients.	Provide resources and guidance, as requested, on developing co-management agreements with asthma specialists and asthma educators. Provide national guidelines for asthma patients.			Primary Care (adult, pedi, and family med), Specialists (pulmonologists/allergist)	Co-management agreements with asthma specialists and asthma educators that meet the requirements of AMCH PPS	9/30/2017	10/10/2017	Period 2
P_019	IDS	2.a.i	Stand Alone		Complete all Phase II contracting Performance Activities for Payment Period 2 in accordance with instructions provided by AMCH PPS by the due date specified.	Track satisfactory completion of Performance Activities.			All	Completed reporting template(s) and all required supporting documentation, for each reporting period within AMCH PPS established timeframes, are required to consider metric achievement completed	9/30/2017	10/10/2017	Period 2
A01_001	IDS	2.a.i	Prerequisite		Host at least one site visit with AMCH PPS and include clinical team members.	Provide requirements of site visit and coordinate with partner to set the date for the visit.			Hospital (ED & inpatient); Primary Care (adult, pedi, and family med); MH (outpatient)	Completed site visit	3/31/2018	4/10/2018	Period 3
A03_003	IDS	2.a.i	Prerequisite		At least one representative from your organization must attend the quarterly PPS forum between October 1, 2017 and March 31, 2018 and share lessons learned with meeting attendees. Representative will report back to staff at respective partner organization.	Host quarterly forum and share documents with attendees to bring back to their respective partner organizations.			All	Proof of attendance via sign-in sheets or webinar sign-in; If you were unable to attend this meeting, review recorded presentation and submit an email attestation of completion	12/31/2017, 3/31/2018	1/10/2018, 4/10/2018	Period 3
A05_002	IDS	2.a.i	Prerequisite		Attend all required VBP education sessions between October 1, 2017 and March 31, 2018 for applicable provider type as defined by AMCH PPS.	Host VBP education sessions and define required sessions per provider type.			All	Attend and sign-in at required VBP sessions	3/31/2018	4/10/2018	Period 3
A06_003	IDS	2.a.i	Prerequisite		Review and confirm all organizational contacts, committee memberships, and National Provider Identification (NPI) numbers assigned to organization.	Provide organizational distribution list, committee memberships, MOVEit users, and assigned NPIs and providers.			All	Submit confirmation of review per AMCH PPS requirements	3/31/2018	4/10/2018	Period 3
A07_003	IDS	2.a.i	Prerequisite		Attend quarterly Cultural Competency/Health Literacy (CCHL) champion meetings between October 1, 2017 and March 31, 2018 to share best practices and network with other attendees.	Organize CCHL champion meetings to allow discussion and information sharing.			All	Signed attendance sheet at CCHL champion meetings; If you were unable to attend this meeting, review recorded presentation and submit an email attestation of completion	12/31/2017, 3/31/2018	1/10/2018, 4/10/2018	Period 3
A09_002	Project Specific	3.a.i - all models	Prerequisite		Identified clinical representative attends at least 80% of all applicable AMCH PPS BH meetings held between October 1, 2017 and March 31, 2018.	Provide meeting information and guidance on the appropriate staff attendance.			Primary Care (adult, pedi, and family med); MH (outpatient); SUD	Sign attendance sheet at all AMCH PPS BH relevant meetings or provide proof of attendance via webinar	3/31/2018	4/10/2018	Period 3
A11_003	Project Specific	2.a.v	Prerequisite		Attend monthly Medical Village Forums between October 1, 2017 and March 31, 2018. Must attend, at minimum, two out of the three meetings per quarter.	Host Medical Village forums.			Primary Care (adult, pedi, and family med); MH (outpatient); SNF; hospital (inpatient); SUD	Sign attendance sheet at Medical Village Forums or provide proof of attendance via webinar; If you were unable to attend this meeting, review recorded presentation and submit an email attestation of completion	12/31/2017, 3/31/2018	1/10/2018, 4/10/2018	Period 3
B01_004	Project Specific	2.a.iii	Bundle	B01 - Health Home at Risk	Provide a quarterly report of all care management plans as outlined in the patient engagement definition using the AMCH PPS provided template and data specifications on a quarterly basis. Must submit four out of five reports to be eligible for payment. A report of zero care management plans does not qualify as a report completion.	Provide patient engagement definitions, template, and data specifications.	Patient Engagment Template	Phase 2 Patient Engagement Template	Primary Care (adult, pedi, and family med)	Completed data template according to AMCH PPS standards and timelines	3/31/2017, 6/30/2017, 9/30/2017, 12/31/2017, 3/31/2018	4/10/2017, 7/10/2017, 10/10/2017, 1/10/2018, 4/10/2018	Period 3
B02_005	Project Specific	3.a.i - M1	Bundle	B02 - BH/PC Integration - Model 1	Have a licensed behavioral health provider available onsite 16 hours per week by December 31, 2017 at minimum number of sites as defined by AMCH PPS.	Provide reasonable guidance, as requested, on integrating behavioral health services at primary care locations. Provide data requirements for supporting documentation. Provide requirements for minimum number of sites.			Primary Care (adult, pedi, and family med)	Provide name(s) of behavioral health provider(s) available onsite by December 2017 and any additional information (hire date, license number, availability, etc.) as defined by ACMH PPS	12/31/2017	1/10/2018	Period 3
B02_006	Project Specific	3.a.i - M1	Bundle	B02 - BH/PC Integration - Model 1	Provide quarterly data for completed clinical depression screenings using a standardized screening tool for people 13 years and older and/or standardized behavioral, developmental and/or autism screening tool for children 12 years or younger, approved by AMCH PPS, using PPS provided template and data specifications. Quarterly report must include the total number of patients seen during the defined timeframe. Must submit four out of five reports to be eligible for payment. A report of zero patients seen during the defined timeframe does not qualify as a report completion.	Provide patient engagement definitions, template and data specifications.	Patient Engagment Template	Phase 2 Patient Engagement Template	Primary Care (adult, pedi, and family med)	Completed patient engagement template according to AMCH PPS standards and timelines	3/31/2017, 6/30/2017, 9/30/2017, 12/31/2017, 3/31/2018	4/10/2017, 7/10/2017, 10/10/2017, 1/10/2018, 4/10/2018	Period 3
B03_007	Project Specific	3.a.i - M3	Bundle	B03 - IMPACT Model	Provide quarterly data for completed clinical depression screenings using a standardized screening tool for people 18 years and older using PPS provided template and data specifications. Quarterly report must include total number of patients seen during the defined timeframe. Must submit four out of five reports to be eligible for payment. A report of zero patients seen during the defined timeframe does not qualify as a report completion.	Provide patient engagement definitions, template and data specifications.	Patient Engagment Template	Phase 2 Patient Engagement Template	Primary Care (adult, pedi, and family med)	Completed patient engagement template according to AMCH PPS standards and timelines	3/31/2017, 6/30/2017, 9/30/2017, 12/31/2017, 3/31/2018	4/10/2017, 7/10/2017, 10/10/2017, 1/10/2018, 4/10/2018	Period 3
B09_006	Project Specific	3.a.i - M2	Bundle	B09 - BH/PC Integration - Model 2	Have a primary care provider (PCPs, NPs or PAs collaborating with a PCP) available onsite 16 hours per week by December 31, 2017.	Provide reasonable guidance, as requested, on integrating primary care services at behavioral health locations.			MH (outpatient Rx only); SUD	Provide name(s) of primary care provider(s) available onsite; Provider template with available and scheduled time slots per week in December 2017 and any additional information (hire date, license number, etc.) as defined by ACMH PPS	12/31/2017	1/10/2018	Period 3
B09_007	Project Specific	3.a.i - M2	Bundle	B09 - BH/PC Integration - Model 2	Provide quarterly data for completed preventive care screenings as identified by applicable CPT codes using AMCH PPS provided template and data specifications (January 2017 to March 2017). Must submit four out of five reports to be eligible for payment. A report of zero patients screened during the defined timeframe does not qualify as a report completion.	Provide patient engagement definitions and template and data specifications.	Patient Engagment Template	Phase 2 Patient Engagement Template	MH (outpatient Rx only); SUD	Completed patient engagement template according to AMCH PPS standards and timelines	3/31/2017, 6/30/2017, 9/30/2017, 12/31/2017, 3/31/2018	4/10/2017, 7/10/2017, 10/10/2017, 1/10/2018, 4/10/2018	Period 3
B10_005	Project Specific	3.b.i	Bundle	B10 - CVD/HTN Management	Track referrals to community based programs, such as CHW programs. Develop and implement a process to follow up on referrals and document participation and behavioral and health status changes. Train identified staff on referral process.	Provide reasonable guidance and support, as requested, on establishing/strengthening the referral process. Provide data specifications for data submission.			Primary Care (adult and family med)	Provide the total number of patients referred to community based programs and number of follow-ups on referrals with documented participation and behavioral and health status changes; Training sign-in sheets with training dates	9/30/2017, 3/31/2018	10/10/2017, 4/10/2018	Period 3
B10_006	Project Specific	3.b.i	Bundle	B10 - CVD/HTN Management	Provide registry data on a quarterly basis for patients who have been diagnosed with hypertension and cardiovascular disease per AMCH PPS data specifications.	Provide assessment/reporting template. Provide instructions and guidance for submission of data. Registry template will be updated as the IT roadmap is developed.	Registry Template	Phase 2 Registry Templates	Primary Care (adult and family med); Outpatient Specialty Care	Completed data template according to AMCH PPS standards and timelines	3/31/2017, 6/30/2017, 9/30/2017, 12/31/2017, 3/31/2018	4/10/2017, 7/10/2017, 10/10/2017, 1/10/2018, 4/10/2018	Period 3
B10_007	Project Specific	3.b.i	Bundle	B10 - CVD/HTN Management	Provide quarterly data for number of patients with documented self-management goals in the EMR, as outlined in the patient engagement definition, using an AMCH PPS provided template and data specifications. Must submit four out of five reports to be eligible for payment. A report of zero patients with documented self-management goals does not qualify as a report completion.	Provide patient engagement definitions, template and data specifications.	Patient Engagment Template	Phase 2 Patient Engagement Template	Primary Care (adult and family med)	Completed data template according to AMCH PPS standards and timelines	3/31/2017, 6/30/2017, 9/30/2017, 12/31/2017, 3/31/2018	4/10/2017, 7/10/2017, 10/10/2017, 1/10/2018, 4/10/2018	Period 3

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B11_003	Project Specific	2.b.iii	Bundle	B11 - ED Utilization	Compile a list of high utilizers as defined by 3+ visits in six months using the AMCH PPS provided template and data specifications on a quarterly basis.	Develop and provide registry data template and data specifications.	Registry Template	Phase 2 Registry Templates	Hospital (ED)	Completed data template according to AMCH PPS standards and timelines	3/31/2017, 6/30/2017, 9/30/2017, 12/31/2017, 3/31/2018	4/10/2017, 7/10/2017, 10/10/2017, 1/10/2018, 4/10/2018	Period 3
B11_004	Project Specific	2.b.iii	Bundle	B11 - ED Utilization	Provide quarterly data for appointments with PCP as outlined in the patient engagement definition using the AMCH PPS provided template and data specifications on a quarterly basis. Must submit four out of five reports to be eligible for payment. A report of zero appointments does not qualify as a report completion.	Provide patient engagement definitions, template, and data specifications.	Patient Engagment Template	Phase 2 Patient Engagement Template	Primary Care (adult, pedi, and family med)	Completed data template according to AMCH PPS standards and timelines	3/31/2017, 6/30/2017, 9/30/2017, 12/31/2017, 3/31/2018	4/10/2017, 7/10/2017, 10/10/2017, 1/10/2018, 4/10/2018	Period 3
B12_002	Outcome Measures Related	Controlling High Blood Pressure	Bundle	B12 - High Blood Pressure Monitoring	Develop protocols to ensure blood pressure measurements are taken correctly, with the correct equipment, and tracked in EMR structured fields accurately by June 30, 2017. Ensure all identified staff have completed new hire (within three months of hire) or annual competency training on appropriate protocols for blood pressure measurements and tracking of measurements in appropriate EMR fields by June 30, 2017. New clinical staff must receive training within three months of hire date and all staff must complete annual competency training.	Provide best-practice guidelines for appropriate blood pressure measurement protocols. Share example of competency assessment tool.			Primary Care (adult and family med)	Protocols developed to ensure correct blood pressure measurements are taken with correct equipment (June 2017); Staff competency tool used to validate knowledge of appropriate techniques; Training report (June 2017 and March 2018) with all identified staff names, hire dates, and training dates	6/30/2017, 3/31/2018	7/10/2017, 4/10/2018	Period 3
B12_003	Outcome Measures Related	Controlling High Blood Pressure	Bundle	B12 - High Blood Pressure Monitoring	Demonstrate that the organization has completed unscheduled follow-up blood pressure checks for HTN patients.	Provide reasonable guidance, as requested, on follow-up blood pressure checks. Provide data specifications for data report to be submitted.			Primary Care (adult and family med)	Provide report (June 2017 and March 2018) of the percentage of HTN patients that received an unscheduled blood pressure check	6/30/2017, 3/31/2018	7/10/2017, 4/10/2018	Period 3
B13_002	Outcome Measures Related	Asthma Measures	Bundle	B13 - Poorly Controlled Asthma	Demonstrate a 10% improvement from baseline (January 2017 to June 2017) gap to goal of 80% OR maintain baseline rate of 80% or higher on rate of asthma controller medications prescribed to persistent and poorly controlled asthmatics between July 2017 to March 2018.	Provide guidance and support, as requested, on opportunities and strategies to improve rate of formulary asthma controller medications prescribed to identified patients per accepted definitions. Provide data specifications for data submission and required improvement goals based on previously submitted baseline.			Primary Care (adult, pedi, and family med); Specialists (pulmonologists/allergists)	Data report that meets AMCH PPS required format and demonstrates required improvement above baseline.	3/31/2018	4/10/2018	Period 3
B13_003	Outcome Measures Related	Asthma Measures	Bundle	B13 - Poorly Controlled Asthma	Demonstrate ability to identify persistent and poorly controlled asthmatics. Produce structured reports in the EMR for asthma registry and applicable asthma measures. EMR templates and reports must meet the data specifications and required data fields as defined by AMCH PPS. Provide quarterly data registry reports. Train all identified staff on protocols to identify patients eligible for asthma controller medications and prescribe preferred formulary medications when applicable.	Provide definitions for persistent and poorly controlled asthmatics, applicable ICD codes, EMR templates, and other applicable data specifications and required data fields for structured reports. Provide reasonable guidance, as requested, and technical assistance on acceptable training components.	Registry Template	Phase 2 Registry Templates	Primary Care (adult, pedi, and family med); Specialists (Pulmonologists/Allergists)	Structured reports in the EMR for asthma registry and applicable asthma measures; Quarterly asthma registry template; Training sign-in sheets with dates for staff that received training	3/31/2017, 6/30/2017, 9/30/2017, 12/31/2017, 3/31/2018	4/10/2017, 7/10/2017, 10/10/2017, 1/10/2018, 4/10/2018	Period 3
B13_004	Project Specific	3.d.iii	Bundle	B13 - Poorly Controlled Asthma	Provide quarterly data for the number of patients with an asthma action plans as outlined in the patient engagement definition using an AMCH PPS provided template and data specifications on a quarterly basis. A report of zero patients with asthma action plans does not qualify as a report completion.	Provide patient engagement definitions, template, and data specifications.	Patient Engagment Template	Phase 2 Patient Engagement Template	Primary Care (adult, pedi, and family med)	Completed data template according to AMCH PPS standards and timelines	3/31/2017, 6/30/2017, 9/30/2017, 12/31/2017, 3/31/2018	4/10/2017, 7/10/2017, 10/10/2017, 1/10/2018, 4/10/2018	Period 3
B14_002	Outcome Measures Related	Asthma Measures	Bundle	B14 - Asthma Control Assessment	Develop and adopt a performance improvement project using a standardized asthma control assessment tool such as Asthma Control Test (ACT) that meets minimum requirements as defined by AMCH PPS. Demonstrate 10% improvement from baseline (March 2017 to September 2017) gap to goal of 80% OR maintain baseline rate of 80% or higher on rate of ACT between October 2017 to March 2018.	Provide requirements and best practices for standardized asthma control assessment tools such as the Asthma Control Test (ACT). Provide data specifications for data submission and improvement goals per partner based on baseline submissions.			Primary Care (adult, pedi, and family med), Specialists (pulmonologists/allergist)	Data report that meets AMCH PPS required format and demonstrates required improvement above baseline	3/31/2018	4/10/2018	Period 3
B15_001	IDS	2.a.i	Bundle	B15 - Training	Adopt DSRIP 101 training and DSRIP compliance training as part of new employee orientation and annual competency for employees identified as key DSRIP staff. Submit attestation that identified staff have completed required training within the appropriate timeframe.	Provide DSRIP 101 and DSRIP compliance training. Provide attestation templates and reasonable guidance, as requested, for completion of required trainings. Define "identified staff".			All	Completed attestation and training template provided by AMCH PPS that identified staff have completed applicable training within applicable timeframe	6/30/2017, 3/31/2018	7/10/2017, 4/10/2018	Period 3
B15_002	IDS	2.a.i	Bundle	B15 - Training	Provide "Intro to Cultural Competency/ Health Literacy (CCHL)" training with pre- and post-training assessments to at least 80% of affected persons.	Provide guidance, as requested, on CCHL training and any necessary technical support. Provide a checklist of minimum requirements for those with existing CCHL 101 curriculum and a template to be completed for reporting purposes when necessary. Define "affected persons".			All	Completed training template or AMCH PPS approved training tracking mechanism	3/31/2018	4/10/2018	Period 3
B16_001	Project Specific	2.d.i	Bundle	B16 - Patient Activation	All community navigators or staff that have been identified as providing navigation services must complete a minimum of: 1. Three hours of patient navigation techniques, including the identification of local community resources 2. Two hours in patient health literacy 3. Two hours in worker cultural competence 4. One hour in alternative ED utilization	Provide training options and resources for applicable provider types.			CBOs; ED; Primary Care (adult, pedi, and family med)	Training dates and sign-in sheets for all identified staff	12/31/2017	1/10/2018	Period 3
B16_002	Project Specific	2.d.i	Bundle	B16 - Patient Activation	At least annually, include beneficiaries in development team to promote preventive care by completing at least one of the following: 1. Include preventative care discussions in patient or consumer advisory group meetings 2. Include preventative care discussions in consumer listening groups 3. Complete a survey of beneficiaries to assess their health needs and that of the local community.	Provide reasonable guidance, as requested, on engaging beneficiaries in program development.			All	Agendas and meeting minutes of patient advisory group (or other event that involves the solicitation of the consumers' input regarding preventative care); Completed survey results, if applicable	3/31/2018	4/10/2018	Period 3
B16_003	Project Specific	2.d.i	Bundle	B16 - Patient Activation	Develop protocols for community navigators to track outreach to primary care practices, in order to link members to services that meets the minimum requirements of AMCH PPS.	Provide requirements for tracking outreach to primary care providers			CBOs	Protocols developed to track outreach to primary care practices; Example tracking log	3/31/2018	4/10/2018	Period 3
B16_004	Project Specific	2.d.i	Bundle	B16 - Patient Activation	Log all results of individuals who completed PAM® in Flourish. Identify duplicate entries for the six month period in the Flourish system and remove them. Partner organization will assess patients utilizing the PAM® and provide CFA support throughout the life of DSRIP.	Provide Flourish access information and guidance, as requested. PMO will generate final report out of Flourish after partner de-duplicates data.		For assistance, please contact Kendal Pompey, MPH PompeyK@mail.amc.edu or Mark Quail, Med QuailM1@mail.amc.edu	All providers participating in 2.d.i	De-duplicated Flourish report	3/31/2017, 6/30/2017, 9/30/2017, 12/31/2017, 3/31/2018	4/10/2017, 7/10/2017, 10/10/2017, 1/10/2018, 4/10/2018	Period 3
B17_001	Outcome Measures Related	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Bundle	B17 - SUD	Adopt evidence-based screening initiatives for alcohol or other drug (AOD) dependence as recommended by AMCH PPS. Integrate screenings into workflow and include a referral process for positive screenings.	Provide evidence based screening initiatives for substance use disorder.			Primary Care (adult, pedi, and family med)	Provide number of patients receiving screening for alcohol or other drug (AOD) dependence and the number of referrals made for a positive screening between January 1, 2017 to December 31, 2017	12/31/2017	1/10/2018	Period 3
B17_002	Outcome Measures Related	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Bundle	B17 - SUD	Develop a referral process to SUD programs that have capacity to book appointments within 14 days of index appointment for patients that have been diagnosed with a SUD, or develop and adopt "warm transfer" protocols for these patients, if applicable.	Provide reasonable guidance, as requested, on referral and communication processes to SUD programs and/or protocols for "warm transfers."			Primary Care (adult, pedi, and family med)	Provide the total number of patients that screened positive for SUD and were referred to a SUD program or resulted in a "warm transfer" when applicable	12/31/2017	1/10/2018	Period 3

Activity ID	Activity Type	Applicable Project or Outcome Measure	Activity Grouping	Bundle #, if applicable	Performance Activity	AMCH PPS Responsibility		PPS Responsibility Documents/ Recordings	Applicable Partner Service Type Summary	Supporting Documentation	Completion Date(s)	Reporting Date(s)	Payment Period
B18_001	Outcome Measures Related	Follow-up Care for Children Prescribed ADHD Medications	Bundle	B18 - Children with ADHD	Develop a process to reach out to parents of children that were newly prescribed ADHD medications and did not complete: 1. Follow-up visit within 30 days after starting medication and/or 2. At least two follow-up visits within nine months after initiation phase ended	Provide reasonable guidance, as requested, on appropriate follow-up care for newly prescribed ADHD medications in children.			Primary Care (pedi and family med); MH (outpatient Rx only)	Total number of completed outreach activities for patients that did not complete follow-up visits within the appropriate timeframe	3/31/2018	4/10/2018	Period 3
B18_002	Outcome Measures Related	Follow-up Care for Children Prescribed ADHD Medications	Bundle	B18 - Children with ADHD	Develop and implement a process for one (1) post-visit call to parents of children with new ADHD medication prescriptions 1-2 weeks after new prescription to ensure that patient fills prescription and is taking medication properly.	Provide reasonable guidance, as requested, on medication adherence outreach strategies for patients who were newly prescribed ADHD medications.			Primary Care (pedi and family med); MH (outpatient)	Provide the total number of post visit calls to parents of children with new ADHD medication prescriptions 1-2 weeks after new prescription from April 1, 2017 to September 30, 2017	12/31/2017	1/10/2018	Period 3
P_020	IDS	2.a.i	Stand Alone		Complete workforce impact analysis on a quarterly basis using AMCH PPS provided template to demonstrate new hires by staff type, and existing staff, that have been trained, retrained, and/or redeployed (% hours dedicated to DSRIP related activities).	Develop and share assessment template with partners. Provide instructions for completion and submission of data.	Impact Analysis Template	Workforce Impact Analysis Template	All	Completed data template on a quarterly basis, according to AMCH PPS requirements; A blank template is acceptable if there are no staffing changes to report	3/31/2017, 6/30/2017, 9/30/2017, 12/31/2017, 3/31/2018	4/10/2017, 7/10/2017, 10/10/2017, 1/10/2018, 4/10/2018	Period 3
P_021	IDS	2.a.i	Stand Alone		Provide registry data for uninsured patients seen at primary care practice, using AMCH PPS template and data specifications, on a quarterly basis	Develop and provide registry template and data specifications.	Registry Template	Phase 2 Registry Templates	Primary Care (pedi, adult and family med)	Completed data template according to AMCH PPS standards and timelines	3/31/2017, 6/30/2017, 9/30/2017, 12/31/2017, 3/31/2018	4/10/2017, 7/10/2017, 10/10/2017, 1/10/2018, 4/10/2018	Period 3
P_022	IDS	2.a.i	Stand Alone		Implement a process to identify and refer Health Home eligible patients to appropriate Health Home services or BHNNY Cares for appropriate care management services if not Health Home eligible. Document the referral of patients to a Health Home and BHNNY Cares, as applicable.	Provide reasonable guidance, as requested, on Health Home eligible patients and referral processes. Provide eligibility requirements for BHNNY Cares referrals.			Primary Care (adult, pedi, and family med); MH (outpatient); Home Care; Outpatient Specialty Care; Hospitals (psych, inpatient, ED); SUD	Quarterly reports of the number of patients referred to Health Home and BHNNY Cares	6/30/2017, 9/30/2017, 12/31/2017, 3/31/2018	7/10/2017, 10/10/2017, 1/10/2018, 4/10/2018	Period 3
P_023	Outcome Measures Related	Follow-up After Hospitalization for Mental Illness (AHPP)	Stand Alone		Adopt and implement transitions of care protocols that include specific follow-up expectations for patients after hospitalization and referrals to a Health Home when appropriate. Review discharge report with patient and appropriate caregiver(s) before patient is discharged.	Provide transitions of care protocols to partners. Provide data specifications for quarterly report.			Hospitals (with psych inpatient)	Provide quarterly data on the number of patients that were discharged after a hospitalization for mental illness and the number of those patients that were referred to Health homes	6/30/2017, 9/30/2017, 12/31/2017, 3/31/2018	7/10/2017, 10/10/2017, 1/10/2018, 4/10/2018	Period 3
P_024	Project Specific	3.b.i	Stand Alone		Develop protocols for a group visit model and make visits available to patients. Demonstrate adoption of a group visit model.	Provide reasonable guidance, as requested, and examples of group visits models.			Primary Care (adult and family med)	Provide protocols for group visit model; Provide number of patients participating in group visits and include dates of visits through June 30, 2017 and through March 31, 2018	6/30/2017, 3/31/2018	7/10/2017, 4/10/2018	Period 3
P_025	Outcome Measures Related	Screening for Clinical Depression and Follow-up	Stand Alone		Develop quality improvement initiative for depression screening and follow-up care using the PDSA framework by September 30, 2017. Demonstrate 10% improvement from baseline (January 2017 to June 2017) gap to goal of 80% OR maintain baseline rate of 80% or higher on: 1. Percent of patients screened for clinical depression using a standardized screening tool approved by AMCH PPS 2. Percent of patients with positive depression screening that received follow-up care within 30 days after positive screening Data must be captured in EMR using structured fields as defined by AMCH PPS for appropriate timeframe (July 2017 to March 2018)	Define structured fields and report format to track the number of patients screened for depression that received follow-up care within 30 days after a positive screening; Provide improvement goals per partner based on baseline submissions and required data format. Provide PDSA framework guidance and support, as requested. Provide list of eligible events that qualify as follow-up care.			Primary Care (adult, pedi, and family med); MH (outpatient); SUD	Quality improvement plan by September 30, 2017; Data report by March 31, 2018 that meets AMCH PPS required format and demonstrates required improvement above baseline	9/30/2017, 3/31/2018	10/10/2017, 4/10/2018	Period 3
P_026	Outcome Measures Related	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Stand Alone		Develop a process to track patients that were referred to a SUD program. Process must include reaching out to patients to schedule appointment and for appointment reminders.	Provide reasonable guidance, as requested, on tracking referred patients.			SUD	Provide the total number of patients that were referred to a SUD program and the total number of those patients that received an appointment reminder	9/30/2017, 3/31/2018	10/10/2017, 4/10/2018	Period 3
P_027	Outcome Measures Related	Follow-up After Hospitalization for Mental Illness (AHPP)	Stand Alone		Demonstrate that protocols have been put in place to identify and reach out to patients that were hospitalized for mental illness, as defined by AMCH PPS, to schedule initial appointment after discharge, and reach out to those that missed follow-up appointment(s). Ensure that protocols include communication with inpatient and/or Health Home care management team(s) for initial outreach and any follow up for missed appointments.	Provide reasonable guidance, as requested, to reach out to patients with mental illness post-discharge. Provide data specifications and minimum requirements for data submission.			MH (outpatient); primary care (adult, pedi, and family med) in project 3.a.i	Provide the total number of patients that received outreach for initial appointment after hospitalization for mental illness	9/30/2017, 3/31/2018	10/10/2017, 4/10/2018	Period 3
P_028	Outcome Measures Related	Asthma Measures	Stand Alone		Adopt and implement an AMCH PPS provided template to gather data and identify root causes for asthma related ED visits or hospitalization.	Provide templates for adoption by hospitals to identify root causes for asthma related ED visits or hospitalization. Provide data specifications for data submission.			Hospital (ED and inpatient)	Completed template and data according to AMCH PPS requirements	9/30/2017, 3/31/2018	10/10/2017, 4/10/2018	Period 3
P_029	Outcome Measures Related	Asthma Measures	Stand Alone		Provide formal asthma education to persistent and poorly controlled asthmatics, or develop protocols to refer persistent and poorly controlled asthmatics to a community educator, home-based medication support or other appropriate community resource for asthma education.	Provide reasonable guidance and support, as requested, on appropriate asthma education for persistent and poorly controlled asthmatics. Provide support to identify appropriate community based organizations that provide asthma education for appropriate referrals when asthma education is not provided at organization. Provide data specifications for data submission.			Primary Care (adult, pedi, and family med), Specialists (pulmonologists/allergist)	Provide the number of persistent and poorly controlled asthmatics, and the number that received education or were referred to a community educator, home-based medication support or other appropriate community resource for asthma education	9/30/2017, 3/31/2018	10/10/2017, 4/10/2018	Period 3
P_030	Outcome Measures Related	Asthma Measures	Stand Alone		Identify persistent and poorly controlled asthmatics in the EMR that have not been seen within four months of last visit and develop protocols to reach out and remind these patients of needed care based on evidence-based guidelines.	Provide reasonable guidance and support, as requested, for protocols to identify poorly controlled asthmatics that have not received care within the appropriate timeframe. Provide data specifications.			Primary Care (adult, pedi, and family med), Specialists (pulmonologists/allergist)	Provide the number of persistent and poorly controlled asthmatics that have not been seen within four months of last visit and the number of those patients that were contacted to come in for care	9/30/2017, 3/31/2018	10/10/2017, 4/10/2018	Period 3
P_031	PCMH	1.A	Stand Alone		Demonstrate the ability to provide patient-centered appointment access that meets the requirements as defined by PCMH standards by: 1. Providing same-day appointments for routine and urgent care 2. Providing routine and urgent-care appointments outside regular business hours 3. Ensuring availability of appointments 4. Monitoring no-show rates	Provide reasonable guidance and support, as requested, for completion of PCMH standards via PCMH vendor. Provide data specifications for data submission.			Primary Care (adult, pedi, and family med)	Data for third next available appointment; Protocols developed to track no show appointments; No show rate data	9/30/2017, 3/31/2018	10/10/2017, 4/10/2018	Period 3
P_032	PCMH	4.A	Stand Alone		Demonstrate that the practice has established a systematic process and criteria for identifying patients who may benefit from care management and monitors the percentage of total patient population identified through this process and criteria. Process must include considerations for two of the following: 1. Behavioral health conditions 2. High cost/high utilization 3. Poorly controlled or complex conditions 4. Social determinants of health	Provide reasonable guidance and support, as requested, for completion of PCMH standards via PCMH vendor. Provide data specifications for data submission.			Primary Care (adult, pedi, and family med)	Criteria and process developed for identification of patients who may benefit from care management by September 30, 2017; Report of the number of patients that were identified to benefit from care management and the number that were referred to care management	9/30/2017, 3/31/2018	10/10/2017, 4/10/2018	Period 3
P_033	Outcome Measures Related	Screening for Clinical Depression and Follow-up	Stand Alone		Develop protocols to accept referrals from primary care providers and schedule appointments within 30 days. Train identified staff on protocols for referrals. Demonstrate that at least 20% of patients referred have received an appointment within 30 days of referral.	Provide reasonable guidance, as requested, on protocols to accept referrals from primary care providers. Provide data specifications and reporting requirements.			MH (outpatient)	Provide data for the number of patients referred and the number of referrals that were scheduled within 30 days	12/31/2017	1/10/2018	Period 3
P_034	Outcome Measures Related	Antidepressant Medication Management	Stand Alone		Track patients who are prescribed antidepressant medication and reach out to those that are overdue for prescription refill to ensure medication adherence.	Provide reasonable guidance, as requested, on improving medication adherence. Provide standards to track patients prescribed antidepressant medication.			Primary Care (adult, pedi, and family med); MH (outpatient Rx only)	Provide evidence that patients prescribed antidepressant medications are tracked and include outreach to patients that were identified as requiring outreach	12/31/2017	1/10/2018	Period 3

Activity ID	Activity Type	Applicable Project or Outcome Measure	Activity Grouping	Bundle #, if applicable	Performance Activity	AMCH PPS Responsibility		PPS Responsibility Documents/ Recordings	Applicable Partner Service Type Summary	Supporting Documentation	Completion Date(s)	Reporting Date(s)	Payment Period
P_035	Outcome Measures Related	Adherence to Antipsychotic Medications for People with Schizophrenia	Stand Alone		Track patients with schizophrenia prescribed antipsychotic medication to ensure that patient fills prescription and is taking medication properly. Reach out to those that are overdue for prescription refill to ensure medication adherence.	Provide reasonable guidance, as requested, on outreach strategies for schizophrenics prescribed antipsychotic medications for medication adherence.			Primary Care (adult and family med); MH (outpatient Rx only)	Provide the total number of patients with schizophrenia prescribed antipsychotic medication that received outreach for being overdue for prescription refill from April 1, 2017 to September 30, 2017	12/31/2017	1/10/2018	Period 3
P_036	PCMH	2.D	Stand Alone		Demonstrate that the practice uses a team to provide a range of patient care services that meet PCMH standards for team-based care by holding scheduled patient care team meetings or a structured communication process focused on individual patient care. Must also meet the following elements: 1. Identify team structure and define roles for clinical and nonclinical team members 2. Use standing orders for services 3. Train and assign members of care team to support patients/families/caregivers in self-management, self-efficacy and behavior change. 4. Train and assign members of the care team to coordinate care for individual patients and manage the population	Provide reasonable guidance and support, as requested, for completion of PCMH standards via PCMH vendor.			Primary Care (adult, pedi, and family med)	Team roster with defined roles for clinical and nonclinical teams; Schedule of patient care team meetings and items discussed at meetings	12/31/2017	1/10/2018	Period 3
P_037	PCMH	4.B	Stand Alone		Develop and adopt a policy and workflow for the development of care plans. Identify and train staff on policies and workflows to ensure all identified patients receive a care plan. Ensure care team and patient/family/caregiver collaborate to develop and update the individual care plan using AMCH PPS provided standardized care plan template and meets minimum requirements as defined by AMCH PPS. Care plan is documented in the EMR and a copy is provided to patient/family/caregiver prior to leaving office.	Provide reasonable guidance and support, as requested, for completion of PCMH standards via PCMH vendor.			Primary Care (adult, pedi, and family med)	Sample of five (5) patient care plans that have been developed in collaboration with patient/family/caregiver using standardized template	12/31/2017	1/10/2018	Period 3
P_038	PCMH	4.E	Stand Alone		Demonstrate that the practice has and uses materials to support patients and families/caregivers in self-management and shared decision making for identified disease states recommended by AMCH PPS by completing three of the following: 1. Using an EMR to identify patient-specific educational resources 2. Providing self-management tools to record self-care results and recording goals in structured EMR template 3. Adopting shared decision making aids 4. Offering or referring patients to structured health education programs such as group classes and peer support	Provide reasonable guidance and support, as requested, for completion of PCMH standards via PCMH vendor. Provide disease states and guidelines for self-management and shared decision making. Provide data specifications for data submission.			Primary Care (adult, pedi, and family med)	Provide the number of patients that were identified to receive patient-specific educational resources and the number of those patients that received the patient-specific educational resources; Examples of resources, tools or aids developed for self-management support and shared decision making activities	12/31/2017	1/10/2018	Period 3
P_039	PCMH	5.B	Stand Alone		Develop a referral tracking and follow-up process that: 1. Maintains agreements with behavioral health care providers 2. Gives the consultant or specialist the clinical question, the required timing and the type of referral 3. Gives the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan 4.Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports	Provide reasonable guidance and support, as requested, for completion of PCMH standards via PCMH vendor			Primary Care (adult, pedi, and family med)	Agreement with a behavioral health care provider or existing process if behavioral health is integrated; De-identified referral forms that meet PCMH 5B Factor 6 minimum requirements; De-identified tracking report	12/31/2017	1/10/2018	Period 3
P_040	IDS	2.a.i	Stand Alone		Continue to administer CG-CAHPS patient experience survey and submit data report for October 2017 to March 2018 timeframe. Demonstrate 10% improvement in survey results from baseline (January 2017 to September 2017) gap to goal of 80% OR maintain baseline rate of 80% or higher.	Provide reasonable guidance, as requested, to improve patient experience survey results. Provide data specifications, required data format, and improvement goals per partner based on baseline submissions.			Primary Care (adult, pedi, and family med)	Provide patient experience data according to AMCH PPS data specifications	3/31/2018	4/10/2018	Period 3
P_041	Outcome Measures Related	Flu Shots for Adults Ages 18 - 64	Stand Alone		Develop and implement a flu vaccine program that includes: 1. Promotion of flu vaccines during flu season 2. Available walk-in appointments for flu shots during flu season 3. Process that ensures staff are asking patients if they have received a flu shot and tracking it in a structured field in the EMR 4. Ability to flag patients in the EMR that have not received a flu shot within the measurement year	Provide reasonable guidance and materials, as requested, on a flu vaccine program. Provide data specifications for data submission.			Primary Care (adult and family med)	Provide the number of patients that received flu vaccines out of the total eligible patient population based on CDC eligible criteria from September 1, 2016 to March 31, 2018	3/31/2018	4/10/2018	Period 3
P_042	Outcome Measures Related	Aspirin Use and Discussion	Stand Alone		Develop and implement a process to: 1. Identify patients that are eligible for an aspirin regimen based on HEDIS criteria 2. Educate and counsel eligible patients on benefits and risks of an aspirin regimen 3. Prescribe an aspirin regimen to eligible patients Track all steps in EMR structured fields/templates.	Provide reasonable guidance and technical assistance, as requested, on aspirin regimens. Provide data specifications for data submission.			Primary Care (adult and family med)	Provide the number of patients that received an aspirin regimen out of the eligible patient population based on HEDIS criteria from September 1, 2016 to March 31, 2018	3/31/2018	4/10/2018	Period 3
P_043	IDS	2.a.i	Stand Alone		Ensure all identified staff have completed self-management training that has been provided by AMCH PPS. All identified staff must have at least one training completed per calendar year, and within three months of hire for new employees.	Provide standardized self-management training materials. Define "identified staff".			Primary Care (adult, pedi, and family med); MH (outpatient); Specialty Care	Training dates with sign-in sheets that include new and existing staff training dates	3/31/2018	4/10/2018	Period 3
P_044	IDS	2.a.i	Stand Alone		Ensure all identified staff have completed motivational interviewing training that has been provided by AMCH PPS.	Provide standardized motivational interviewing training materials. Define "identified staff".			Primary Care (adult, pedi, and family med); MH (outpatient); Specialty Care	Training dates with sign-in sheets that include new and existing staff training dates.	3/31/2018	4/10/2018	Period 3
P_045	IDS	2.a.i	Stand Alone		Complete all Phase II contracting Performance Activities for Payment Period 3 in accordance with instructions provided by AMCH PPS by the due date specified.	Track satisfactory completion of Performance Activities.			All	Completed reporting template(s) and all required supporting documentation, for each reporting period within AMCH PPS established timeframes, are required to consider metric achievement completed	3/31/2018	4/10/2018	Period 3