Suffolk Care
Collaborative

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Domain 1 Patient Engagement Speed Data Reports & Schedule

Suffolk Care Collaborative (SCC)

Suffolk County Performing Provider System (PPS)

Delivery System Reform Incentive Payment (DSRIP) Program

PRESENTATION OBJECTIVES

- Overview of DSRIP Project Domain 1 Patient Engagement Speed & Scale
- Outline SCC Data Request Schedule FY 2015
- Outline the SCC Data Request & Instructions to submit reports by project
- Question & Answers

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DOMAIN 1 PATIENT ENGAGEMENT SPEED METRICS

- DSRIP payments are achieved by successfully meeting Domain 1 Process Milestones and Metrics, Pay for Reporting requirements, and meeting and/or exceeding Pay for Performance metrics.
- Patient engagement speed is a Domain 1 Process Measure.
- Domain 1 Process Measure funding is significant, representing approximately 40% of all payments across the 5 year waiver.
- All Speed and Scale measures tie directly to commitments made in the Project Plan Application submitted by the Suffolk PPS.
- The definition of the term ‘Actively Engaged’ varies by project and is outlined within this presentation.

Source: NYS DOH Presentation entitled “Actively Engaged Patients: Counting Methodology for Speed & Scale Tables“ December 17, 2014

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DSRIP METRIC & MILESTONE DOMAINS

Metric/Milestone Domains	Performance Payment*	Year 1 (CY 15)	Year 2 (CY 16)	Year 3 (CY 17)	Year 4 (CY18)	Year 5 (CY 19)
Project progress Milestones (Domain 1) ★	P4R/ P4P	80%	60%	40%	20%	0%
System Transformation and Financial Stability Milestones (Domain 2)	P4P	0%	0%	20%	35%	50%
	P4R	10%	10%	5%	5%	5%
Clinical Improvement Milestones (Domain 3)	P4P	0%	15%	25%	30%	35%
	P4R	5%	10%	5%	5%	5%
Population health Outcome Milestones (Domain 4)	P4R	5%	5%	5%	5%	5%

** P4P is pay for performance; P4R is pay for reporting.*

★ *Patient Engagement Speed metrics are a component of Domain 1 Project Progress Milestones*

Source: Department of Health presentation on April 21, 2015 entitled "DSRIP Domain 1 Achievement Values "

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DOMAIN 1 PATIENT ENGAGEMENT SPEED TARGETS

	DY 1			DY 2				DY 3				DY 4			
Project	Q2: July 1-September 30, 2015	Q3: October 1-December 31, 2015	Q4: January 1-March 31, 2016	Q1: April 1-June 30, 2016	Q2: July 1-September 30, 2016	Q3: October 1-December 31, 2016	Q4: January 1-March 31, 2017	Q1: April 1-June 30, 2017	Q2: July 1-September 30, 2017	Q3: October 1-December 31, 2017	Q4: January 1-March 31, 2018	Q1: April 1 - June 30, 2018	Q2: July 1-September 30, 2018	Q3: October 1-December 31, 2018	Q4: January 1-March 31, 2019
2B4 - TOC	25%	38%	60%	8%	40%	60%	100%	10%	50%	75%	100%	10%	50%	75%	100%
Patient Count	6354	9531	15255	2034	10170	15255	25326	2543	12713	19018	25326	2543	12713	19018	25326
2B7 - INTERACT	25%	37%	60%	20%	40%	70%	100%	25%	50%	75%	100%	25%	50%	75%	100%
Patient Count	478	717	1148	382	765	1340	1914	478	957	1435	1914	478	957	1435	1914
2B9 - OBS	10%	25%	40%	10%	35%	56%	75%	25%	50%	75%	100%	25%	50%	75%	100%
Patient Count	886	2216	3546	886	3103	4987	6650	2216	4433	6650	8866	2216	4433	6650	8866
2D1 – PAM	10%	18%	25%	4%	20%	35%	50%	7%	35%	53%	75%	10%	50%	75%	100%
Patient Count	4542	7950	11356	1817	9085	15899	22712	3180	15899	23849	34069	4542	22712	34069	45426
3A1 - BH-PC	5%	10%	15%	4%	20%	35%	50%	8%	40%	53%	75%	10%	50%	75%	100%
Patient Count	2245	4505	6785	1799	8995	15770	22489	3598	17991	23849	33734	4498	22489	33734	45059
3B1 - CV	10%	15%	25%	4%	20%	35%	50%	8%	40%	60%	80%	10%	50%	75%	100%
Patient Count	1453	2180	3663	581	2907	5095	7267	1163	5814	8734	11628	1453	7267	10917	14556
3C1 - DIABETES	25%	37%	50%	8%	40%	60%	80%	10%	50%	75%	100%	10%	50%	75%	100%
Patient Count	3022	4533	6044	967	4834	7251	9669	1209	6044	9066	12094	1209	6044	9066	12094
3D2 - ASTHMA	10%	32%	40%	10%	50%	62%	75%	10%	50%	75%	100%	10%	50%	75%	100%
Patient Count	674	2180	2697	674	3371	4214	5057	674	3371	5065	6751	674	3371	5065	6751

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DSRIP QUARTERLY REPORTING SCHEDULE

Demonstration Year & Quarter*	Reporting Period	Quarterly Report Due
DY 1, Q1	4/1/15 – 6/30/15	August 7, 2015 (Completed)
DY 1, Q2	**7/1/15 - 9/30/15**	**October 31, 2015**
DY 1, Q3	10/1/15 – 12/31/15	January 31, 2015
DY 1, Q4	1/1/16 – 3/31/16	April 30, 2016
DY 2, Q1	4/1/16 – 6/30/16	July 31, 2016
DY 2, Q2	7/1/16 – 9/30/16	October 31, 2016
DY 2, Q3	10/1/16 – 12/31/16	January 31, 2017
DY 2, Q4	1/1/17- 3/31/17	April 30, 2017
DY 3, Q1	4/1/17 – 6/30/17	July 31, 2017
DY 3, Q2	7/1/17 – 9/30/17	October 31, 2017
DY 3, Q3	10/1/17 – 12/31/17	January 31, 2018

Table continues through DY 5*

Source: Department of Health presentation on April 21, 2015 entitled "DSRIP Domain 1 Achievement Values "

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SCC DATA REQUEST SCHEDULE FY 2015

Demonstration Year & Quarter*	Reporting Period	Quarterly Report Due

- SCC will formally request forecasting data on 8/10/2015 (No PHI required)
- Data files due back to the SCC by 8/31/2015 (No PHI required)
- SCC will determine partners to execute a BAA for the DY 1, Q2 data request outlined below.

PHI Request #1: DY 1, Q2	**7/1/15 - 9/30/15**	**October 31, 2015**

- SCC will formally request data on 10/1/2015
- Data files due back to the SCC by 10/12/2015
- SCC will reconcile data against all partner submissions 10/12/2015-10/23/2015
- SCC will follow up with partner with any questions or concerns 10/12/2015-10/23/2015
- SCC will prepare aggregated file for final metric count 10/26/2015
- SCC will report metrics 10/31/2015

PHI Request #2: DY 1, Q3	**10/1/15 – 12/31/15**	**January 31, 2016**

- SCC will formally request data on 1/4/2016
- Data files due back to the SCC by 1/15/2016
- SCC will reconcile data against all partner submissions 1/15/2016-1/22/2016
- SCC will follow up with partner with any questions or concerns 1/15/2016-1/22/2016
- SCC will prepare aggregated file for final metric count 1/23/2016
- SCC will report metrics 1/31/2016

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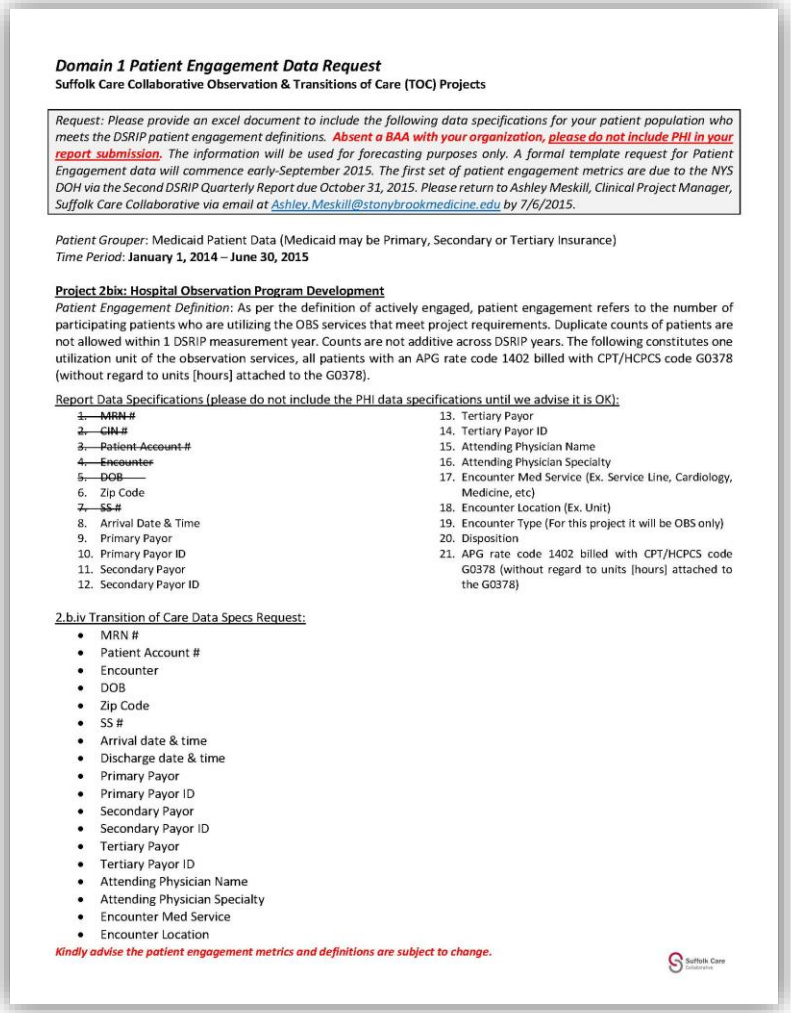
DESCRIBE SCC DATA REQUESTS



Domain 1 Patient Engagement Data Request

Suffolk Care Collaborative Observation & Transitions of Care (TOC) Projects

Request: Please provide an excel document to include the following data specifications for your patient population who meets the DSRIP patient engagement definitions. ***Absent a BAA with your organization, please do not include PHI in your report submission****. The information will be used for forecasting purposes only. A formal template request for Patient Engagement data will commence early-September 2015. The first set of patient engagement metrics are due to the NYS DOH via the Second DSRIP Quarterly Report due October 31, 2015. Please return to Ashley Meskill, Clinical Project Manager, Suffolk Care Collaborative via email at Ashley.Meskill@stonybrookmedicine.edu by 7/6/2015.*

Patient Grouper: Medicaid Patient Data (Medicaid may be Primary, Secondary or Tertiary Insurance)
Time Period: **January 1, 2014 – June 30, 2015**

Project 2bix: Hospital Observation Program Development

Patient Engagement Definition: As per the definition of actively engaged, patient engagement refers to the number of participating patients who are utilizing the OBS services that meet project requirements. Duplicate counts of patients are not allowed within 1 DSRIP measurement year. Counts are not additive across DSRIP years. The following constitutes one utilization unit of the observation services, all patients with an APG rate code 1402 billed with CPT/HCPCS code G0378 (without regard to units [hours] attached to the G0378).

Report Data Specifications (please do not include the PHI data specifications until we advise it is OK):

1. ~~MRN #~~
2. ~~CIN #~~
3. ~~Patient Account #~~
4. ~~Encounter~~
5. ~~DOB~~
6. Zip Code
7. ~~SS #~~
8. Arrival Date & Time
9. Primary Payor
10. Primary Payor ID
11. Secondary Payor
12. Secondary Payor ID
13. Tertiary Payor
14. Tertiary Payor ID
15. Attending Physician Name
16. Attending Physician Specialty
17. Encounter Med Service (Ex. Service Line, Cardiology, Medicine, etc)
18. Encounter Location (Ex. Unit)
19. Encounter Type (For this project it will be OBS only)
20. Disposition
21. APG rate code 1402 billed with CPT/HCPCS code G0378 (without regard to units [hours] attached to the G0378)

2.b.iv Transition of Care Data Specs Request:

- MRN #
- Patient Account #
- Encounter
- DOB
- Zip Code
- SS #
- Arrival date & time
- Discharge date & time
- Primary Payor
- Primary Payor ID
- Secondary Payor
- Secondary Payor ID
- Tertiary Payor
- Tertiary Payor ID
- Attending Physician Name
- Attending Physician Specialty
- Encounter Med Service
- Encounter Location

Kindly advise the patient engagement metrics and definitions are subject to change.

- SCC Data Requests are 1 pg. documents describing specifications for each of the applicable Domain 1 Patient Engagement Speed Metric requirements
- PHI is required (unless otherwise stated on the request)
- Data requests are designed by project and by provider type
- Instructions are defined on the top of the page
- Specifications are defined in the body of the page

FAQ

Q: How will ICD-10 impact reporting?

A: ICD-10 has been delayed with an expected live date of October 1, 2015. This doesn't affect the October 2015 report however, we do need to prepare for ICD-10. This does not change CPT codes. SCC has in place a process to convert current definitions into ICD-10 definitions where applicable for the PHI Request #2: DY 1, Q3.

Q: What is the payor mix for reporting?

A: Straight Medicaid, Medicaid Managed Care plans, and if either is the primary, secondary or tertiary insurance. Dual eligible with Medicare is also included. The uninsured population is only applicable for Project 2di patient engagement.

Q: What is the DOH provider type as the data source for each request?

A: Our next slide will outline what provider type data can be used to “count” patient engagement.

PROVIDER TYPE SELECTION FOR REPORTING

The following table will help outline “who” you will obtain this patient engagement data from…

Project Name	Provider Type
2biv TOC	Hospital Data
2bix OBS	Hospital Data
2di PAM	Insignia Licensed Tool Database
2bvii Interact	Skilled Nursing Facilities (SNF)
3ai Model 1	Primary Care Physician (PCP) practice data
3ai Model 2	Behavioral Health (BH) practice data with PCP Services
3ai Model 3	PCP practice data
3bi Cardiovascular	PCP, Non-PCP, or BH practice data
3ci Diabetes	Hospital, PCP, Non-PCP, or Care Management registry database
3dii Asthma	PCP practice data

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SCC DSRIP DOMAIN 1 PATIENT ENGAGEMENT SPEED METRICS & TARGETS: PROJECT 2BIV

Project Title	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions
Actively Engaged Definition	The number of participating patients with a care transition plan developed prior to discharge.
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are allowed, provided that they meet the criteria more than once. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- There is no specific definition of a "care transition plan." However, a care transition plan should be consistent with the best practices of CMS' Community-Based Care Transitions Program and should include core components such as: **patient self-education, follow-up appointments, and medication reconciliation.**
- "Participating patients" refers to those patients who are at a high risk of readmission, particularly those patients with cardiac, renal, diabetic, respiratory and/or behavioral health disorders. These are the same patients who would fit the 3M definitions for successfully prevented readmissions. While the project is specifically focused on certain conditions, any hospitalized patients who receive a care transition plan prior to discharge will count.
- The discharge needs to be accompanied by a care transition plan in order for that patient to count as actively engaged, i.e. if a patient is discharged with the intent to develop a treatment plan within a predetermined number of hours/days/etc., that patient would not count as actively engaged.

Source: NYS DOH Presentation "Revised DSRIP Actively Engaged: Project Specific Definitions & Clarifying Information" As of July 29, 2015

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SCC DSRIP DOMAIN 1 PATIENT ENGAGEMENT SPEED METRICS & TARGETS: PROJECT 2BVII

Project Title	Implementing the INTERACT project (inpatient transfer avoidance program for SNF)
Actively Engaged Definition	The number of participating patients who avoided nursing home to hospital transfer, attributable to INTERACT principles as established within the project requirements.
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- The count refers to the number of patients participating in the INTERACT program.
- Any patient who was transferred to an acute facility (including an ER visit, even if they were not admitted to the hospital) from the nursing home would not count in the actively engaged population.

Source: NYS DOH Presentation "Revised DSRIP Actively Engaged: Project Specific Definitions & Clarifying Information" As of July 29, 2015

SCC DSRIP DOMAIN 1 PATIENT ENGAGEMENT SPEED METRICS & TARGETS: PROJECT 2BIX

Project Title	Implementation of observational programs in hospitals
Actively Engaged Definition	The number of participating patients who are utilizing the OBS services that meet project requirements.
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- One utilization unit of the observation services consists of:
- One episode of care = APG rate code 1402 billed with CPT/HCPCS code G0378 (without regard to units [hours] attached to the G0378). This may vary by Hospital.
- Patients transferred to an Inpatient status from an Observation status would not count.

Source: NYS DOH Presentation "Revised DSRIP Actively Engaged: Project Specific Definitions & Clarifying Information" As of July 29, 2015

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SCC DSRIP DOMAIN 1 PATIENT ENGAGEMENT SPEED METRICS & TARGETS: PROJECT 2DI

Project Title	Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non- utilizing Medicaid populations into Community Based Care
Actively Engaged Definition	The number of individuals who completed PAM®
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- Currently PAM® is the only activation measure being considered for implementation in this project.
- If any other patient engagement technique is utilized it must be evidence-based and/or peer reviewed, demonstrating that it is a patient activation technique that is equal to or better than PAM®.
- PAM® surveys completed by parents/guardians on behalf of younger patients would count for active engagement.

Source: NYS DOH Presentation "Revised DSRIP Actively Engaged: Project Specific Definitions & Clarifying Information" As of July 29, 2015

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SCC DSRIP DOMAIN 1 PATIENT ENGAGEMENT SPEED METRICS & TARGETS: PROJECT 3AI MODEL 1

Project Title	Integration of primary care and behavioral health services
Actively Engaged Definition	The total number of patients receiving appropriate preventive care screenings that include mental health/SA.
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:
SCC Data request is for: Number of patients (ages 13 and up) screened with PHQ2 or PHQ9
OR Number of patients (ages 13 and up) screened using SBIRT tools including both AUDIT and DAST
OR Number of patients (ages 4-12) screened with Pediatric Symptom Checklist (PSC or Y-PSC)
**The use of developmental and behavioral screening tools can be reported using the CPT code 96110.*
OR Number of patients (ages 13 -17) screened using SBIRT tools including the CRAFFT

- The PPS is expected to utilize the preventive care screening based on nationally-accepted best practices determined to be age-appropriate.
- Any staffer working at a PCMH/APCM Service Site who is qualified to perform a preventive care screening can do so
- Appropriate screenings would only count if the PCP is provided the results of the screen and they are incorporated into the medical record.
- The expectation of a co-located primary care-behavioral health site is that there is a behavioral health provider (licensed social worker, psychologist, psychiatric nurse practitioner, psychiatrist) on site engaged in the practice.

Source: NYS DOH Presentation "Revised DSRIP Actively Engaged: Project Specific Definitions & Clarifying Information" As of July 29, 2015

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SCC DSRIP DOMAIN 1 PATIENT ENGAGEMENT SPEED METRICS & TARGETS: PROJECT 3AI MODEL 2

Project Title	Integration of primary care and behavioral health services
Actively Engaged Definition	The total number of patients receiving primary care services at a participating mental health or substance abuse site.
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- Primary Care Services are defined as preventive care screenings billed through Current Procedural Terminology (CPT) codes.
- The mental health and substance abuse sites have to be partners in the Network Tool in order to count as sites included from the network list.
- Any staffer working at a Behavioral Health Site who is qualified to perform a preventive care screening as required within the project can do so.
- The only types of "primary care providers" that may be utilized to provide primary care services within the BH site are participating PCPs, NPs, and physician assistants working closely with a PCP.

Source: NYS DOH Presentation "Revised DSRIP Actively Engaged: Project Specific Definitions & Clarifying Information" As of July 29, 2015

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SCC DSRIP DOMAIN 1 PATIENT ENGAGEMENT SPEED METRICS & TARGETS: PROJECT 3AI MODEL 3

Project Title	Integration of primary care and behavioral health services
Actively Engaged Definition	The total number of patients screened using the PHQ-2 or 9 / SBIRT.
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:
SCC Data request is for: Number of patients (ages 13 and up) screened with PHQ2 or PHQ9
OR Number of patients (ages 13 and up) screened using SBIRT tools including both AUDIT and DAST
OR Number of patients (ages 4-12) screened with Pediatric Symptom Checklist (PSC or Y-PSC)
**The use of developmental and behavioral screening tools can be reported using the CPT code 96110.*
OR Number of patients (ages 13 -17) screened using SBIRT tools including the CRAFFT

- SCC has put forth a question to the DOH regarding the approved screening tools for patients under 13.
- All five principles of the IMPACT model must be in place for a site to count.
- Any staffer working within the IMPACT model who is qualified to perform a preventive care screening as required within the project can do so.

Source: NYS DOH Presentation "Revised DSRIP Actively Engaged: Project Specific Definitions & Clarifying Information" As of July 29, 2015

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SCC DSRIP DOMAIN 1 PATIENT ENGAGEMENT SPEED METRICS & TARGETS: PROJECT 3BI

Project Title	Evidence-based strategies for disease management in high risk/affected populations. (adult only)
Actively Engaged Definition	The number of participating patients receiving services from participating providers with documented self- management goals in medical record (diet, exercise, medication management, nutrition, etc.).
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries or medical records).

Clarifying Information:

- Core components require documentation of patient-driven, self-management goals in the medical record, which are reviewed at every appointment.
- Information must be updated in the medical record on an ongoing basis and goals should be reviewed at every appointment.
- Key patient information needs to be available through the HIE throughout the PPS. This is needed so that, for example, a cardiologist and PCP seeing the same patient can access the same information through the RHIO.
- Participating provider systems undertaking this project will be required to engage a majority (at least 80%) of their primary care practices in this activity (as stated in the Domain 1 DSRIP Project Requirements Milestones and Metrics document).

Source: NYS DOH Presentation "Revised DSRIP Actively Engaged: Project Specific Definitions & Clarifying Information" As of July 29, 2015

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SCC DSRIP DOMAIN 1 PATIENT ENGAGEMENT SPEED METRICS & TARGETS: PROJECT 3CI

Project Title	Evidence-based strategies for disease management in high risk/affected populations. (adult only)
Actively Engaged Definition	The number of participating patients with at least one hemoglobin A1c test **within the previous Demonstration Year (DY).**
Counting Criteria	A count of patients at-risk for or with diabetes who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information: As per the definition of actively engaged, patient engagement refers to the number of participating patients with at least one hemoglobin A1c test within previous Demonstration Year (DY). Duplicate counts of patients are not allowed within 1 DSRIP measurement year. Counts are not additive across DSRIP years.

The target population should include individuals:

1) Who have diabetes based on a principal or secondary ICD-9 diagnosis code of 250.00-250.93 **or**
2) A1C $\geq$ 6.4 **or**
3) Are "at-risk" for diabetes based on Table 2.2 of the ADA's Diabetes Care website indicating the criteria for testing for diabetes or pre-diabetes in asymptomatic adults). It should be noted that to be considered a patient "at-risk" the individual would have to demonstrate sufficient risk factors or clear cut symptoms prior to official diagnosis as outlined in Table 2.2.

Source: NYS DOH Presentation "Revised DSRIP Actively Engaged: Project Specific Definitions & Clarifying Information" As of July 29, 2015

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TABLE 2.2 FOR PROJECT 3CI PATIENT ENGAGEMENT REPORTING METRICS

Table 2.2—Criteria for testing for diabetes or prediabetes in asymptomatic adults

1. Testing should be considered in all adults who are overweight (BMI ≥25 kg/m^2 or ≥23 kg/m^2 in Asian Americans) and have additional risk factors:
   - physical inactivity
   - first-degree relative with diabetes
   - high-risk race/ethnicity (e.g., African American, Latino, Native American, Asian American, Pacific Islander)
   - women who delivered a baby weighing >9 lb or were diagnosed with GDM
   - hypertension (≥140/90 mmHg or on therapy for hypertension)
   - HDL cholesterol level <35 mg/dL (0.90 mmol/L) and/or a triglyceride level >250 mg/dL (2.82 mmol/L)
   - women with polycystic ovary syndrome
   - A1C ≥5.7%, IGT, or IFG on previous testing
   - other clinical conditions associated with insulin resistance (e.g., severe obesity, acanthosis nigricans)
   - history of CVD
2. For all patients, particularly those who are overweight or obese, testing should begin at age 45 years.
3. If results are normal, testing should be repeated at a minimum of 3-year intervals, with consideration of more frequent testing depending on initial results (e.g., those with prediabetes should be tested yearly) and risk status.

Source: http://care.diabetesjournals.org/content/38/Supplement_1/S8/T2.expansion.html

SCC DSRIP DOMAIN 1 PATIENT ENGAGEMENT SPEED METRICS & TARGETS: PROJECT 3DII

Project Title	Expansion of asthma home-based self-management program
Actively Engaged Definition	The number of participating patients based on home assessment log, patient registry, or other IT platform.
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- Any IT platform will count for determining the number of participating patients as long as it is able to meet the requirements of accurately documenting persons participating in the program.
- Any program that meets the project requirements and is based on evidence-based guidelines will count as an “asthma home-based self-management program.”

Source: NYS DOH Presentation “Revised DSRIP Actively Engaged: Project Specific Definitions & Clarifying Information” As of July 29, 2015

For more information, please contact:

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Thank you!

Question & Answer