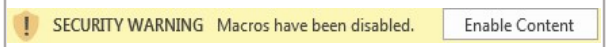
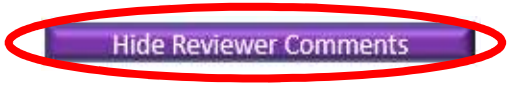
New York State Department of Health
Delivery System Reform Incentive Payment (DSRIP) Program

Achievement Value (AV) Scorecard
Suffolk Care Collaborative

General Instructions		
Step	**Description/Link**	**Image**
1. Enable Content	Click "Enable Content" at the top of the screen to enable macros.	
2. Review AV Scorecard Overview	The AV scorecard Overview is a summary of the report	Click to Access AV Scorecard Overview

Functionality		
Step	**Description/Link**	**Image**
1. Print	All tabs include a print button in the upper left hand corner. The AV Scorecard Overview tab also includes a "Print All" button which will print all relevany reports.	
2. Access Detailed Project Reports and return to AV Scorecard Overview	The AV Scorecard Overview tab is the landing page from which detailed project reports can be viewed. From the AV Scorecard Overview" click the relevant project button to access the project tab. From the project tab click "Save and Return" to access the AV Scorecard Overview	
3. Show or Hide reviewer comments	Each project tab includes a Show/Hide Reviewer Comments button on the left hand side of the screen. Click "Show Reviewer Comments" to show comments and "Hide Reviewer Comments" to hide comments.	

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Print Summary

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Achievement Value (AV) Scorecard
Suffolk Care Collaborative

PPS Information	
Quarter	DY3, Q2 July 1, 2017 - September 30, 2017 (Payment Quarter)
PPS	Suffolk Care Collaborative
PPS Number	16

Achievement Value (AV) Scorecard Summary

Project Link (click on the purple link below to access each individual project report)	AV Data				Payment Data	
	AVs Available	AVs Awarded	AV Adjustment	Net AVs Awarded	DY3, Q2 Payment Available	DY3, Q2 Payment Earned
Domain I Organizational (All Projects)	5.00	5.00	0.00	5.00	*Organizational funds are embedded within each project's payment*	
2.a.i	20.00	20.00	0.00	20.00	$ 1,831,542	$ 1,831,542
2.b.iv	21.00	21.00	0.00	21.00	$ 1,406,362	$ 1,406,362
2.b.vii	21.00	21.00	0.00	21.00	$ 1,340,950	$ 1,340,950
2.b.ix	22.00	21.00	0.00	21.00	$ 1,177,420	$ 1,042,857
2.d.i	10.00	10.00	0.00	10.00	$ 1,279,694	$ 1,279,694
3.a.i	16.00	10.50	0.00	10.50	$ 2,551,076	$ 1,674,143
3.b.i	14.00	13.00	0.00	13.00	$ 1,942,396	$ 1,812,903
3.c.i	12.00	12.00	0.00	12.00	$ 1,962,366	$ 1,962,366
3.d.ii	14.00	13.00	0.00	13.00	$ 2,027,778	$ 1,774,306

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4.a.ii	16.00	16.00	0.00	16.00	$ 1,308,244	$ 1,308,244
4.b.ii	22.00	22.00	0.00	22.00	$ 1,112,007	$ 1,112,007
AV Adjustments (Column F)						
Total	**188.00**	**179.50**	**0.00**	**179.50**	**$ 17,939,835**	**$ 16,545,375**

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Achievement Value (AV) Scorecard DY3, Q2 July 1, 2017 - September 30, 2017 (Payment
Suffolk Care Collaborative - Domain 1 Organizational AVs

Domain I Organizational Scoresheet						
Domain I Organizational	**Review Status**	**AVs Available**	**AVs Awarded**	**Adjustments**	**Net AVs**	**AV**
Workforce Strategy	Complete	1.00	1.00	0.00	1.00	100%
Section 01 - Budget	Complete	1.00	1.00	0.00	1.00	100%
Section 02 - Governance	Complete	1.00	1.00	0.00	1.00	100%
Section 03 - Financial Sustainability	Complete	1.00	1.00	0.00	1.00	100%
Section 04 - Cultural Competency & Health Literacy	Complete	1.00	1.00	0.00	1.00	100%
Section 05 - IT Systems and Processes	Complete	N/A	N/A	N/A	N/A	N/A
Section 06 - Performance Reporting	Complete	N/A	N/A	N/A	N/A	N/A
Section 07 - Practitioner Engagement	Complete	N/A	N/A	N/A	N/A	N/A
Section 08 - Population Health Management	Complete	N/A	N/A	N/A	N/A	N/A
Section 09 - Clinical Integration	Complete	N/A	N/A	N/A	N/A	N/A
Section 10 - General Project Reporting	Complete	N/A	N/A	N/A	N/A	N/A
Total	**Complete**	**5.00**	**5.00**	**0.00**	**5.00**	**100%**

Net Organizational AVs Awarded: 5 out of 5

Hide Reviewer Comments

Workforce Strategy							
Process Measure	**AV Driving**	**Milestone**	**Required Due Date**	**Committed Due Date**	**Milestone Status**	**Reviewer Status**	**AV Awarded**
Workforce Strategy Budget Updates							
	●	Workforce Strategy Spending (Baseline)	Ongoing	N/A	Completed	Pass & Complete	

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Achievement Value (AV) Scorecard DY3, Q2 July 1, 2017 - September 30, 2017 (Payment
Suffolk Care Collaborative - Domain 1 Organizational AVs

Additional Workforce Strategy Budget Updates (non AV-driving)		1. Define target workforce state (in line with DSRIP program's goals)	12/31/2016	N/A	Completed	Pass & Complete	1
		2. Create a workforce transition roadmap for achieving defined target workforce	3/31/2016	N/A	Completed	Pass & Complete	
		3. Perform detailed gap analysis between current state assessment of workforce and projected future state	N/A	N/A	In Process	Pass & Ongoing	
		4. Produce a compensation and benefit analysis, covering impacts on both retrained and redeployed staff, as well as new hires, particularly focusing on full and partial placements	N/A	N/A	In Process	Pass & Ongoing	
		5. Develop training strategy	N/A	N/A	In Process	Pass & Ongoing	
		Major Risks to Implementation & Risk Mitigation Strategies	N/A	N/A	In Process	Pass & Ongoing	

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Additional Workforce Strategy Topic Areas							N/A
		Major Dependencies on Organizational Workstreams	N/A	N/A	In Process	Pass & Ongoing	
		Roles and Responsibilities	N/A	N/A	In Process	Pass & Ongoing	
		Key Stakeholders	N/A	N/A	In Process	Pass & Ongoing	
		IT Expectations	N/A	N/A	In Process	Pass & Ongoing	
		Progress Reporting	N/A	N/A	In Process	Pass & Ongoing	
Total							**1**

Section 01 Budget							
Process Measure	**AV Driving**	**Milestone**	**Required Due Date**	**Committed Due Date**	**Milestone Status**	**Reviewer Status**	**AV Awarded**
		Module 1.1 - PPS Budget Report (Baseline)	Ongoing	N/A	Completed	Pass & Complete	

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Achievement Value (AV) Scorecard DY3, Q2 July 1, 2017 - September 30, 2017 (Payment
Suffolk Care Collaborative - Domain 1 Organizational AVs

Quarterly Project Reports, Project Budget and Flow of Funds							
	●	Module 1.2 - PPS Budget Report (Quarterly	Ongoing	N/A	In Process	Pass & Ongoing	
	●	Module 1.3 - PPS Flow of Funds (Baseline)	Ongoing	N/A	Completed	Pass & Complete	1
	●	Module 1.4 - PPS Flow of Funds (Quarterly)	Ongoing	N/A	In Process	Pass & Ongoing	
	●	Quarterly Progress Reports	N/A	N/A	In Process	Pass & Ongoing	
Total							**1**

Section 02 Governance							
Process Measure	**AV Driving**	**Milestone**	**Required Due Date**	**Committed Due Date**	**Milestone Status**	**Reviewer Status**	**AV Awarded**
Governance Structure	●	1. Finalize governance structure and sub-committee structure	9/30/2015	N/A	Completed	Pass & Complete	
	●	2. Establish a clinical governance structure, including clinical quality committees for each DSRIP project	9/30/2015	N/A	Completed	Pass & Complete	

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Achievement Value (AV) Scorecard DY3, Q2 July 1, 2017 - September 30, 2017 (Payment
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Updates							1
		3. Finalize bylaws and policies or Committee Guidelines where applicable	6/30/2015	N/A	Completed	Pass & Complete	
Governance Process Update		4. Establish governance structure reporting and monitoring processes	12/31/2015	N/A	Completed	Pass & Complete	
Additional Governance Milestones (non AV-driving)		5. Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services,	3/31/2016	N/A	Completed	Pass & Complete	N/A
		6. Finalize partnership agreements or contracts with CBOs	N/A	N/A	In Process	Pass & Ongoing	
		7. Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and	9/30/2016	N/A	Completed	Pass & Complete	
		8. Finalize workforce communication and engagement plan	6/30/2016	N/A	Completed	Pass & Complete	

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Achievement Value (AV) Scorecard DY3, Q2 July 1, 2017 - September 30, 2017 (Payment
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		9. Inclusion of CBOs in PPS Implementation	N/A	N/A	In Process	Pass & Ongoing	
Additional Governance Topic Areas		Major Risks to Implementation & Risk Mitigation Strategies	N/A	N/A	In Process	Pass & Ongoing	N/A
		Major Dependencies on Organizational Workstreams	N/A	N/A	In Process	Pass & Ongoing	
		Roles and Responsibilities	N/A	N/A	In Process	Pass & Ongoing	
		Key Stakeholders	N/A	N/A	In Process	Pass & Ongoing	
		IT Expectations	N/A	N/A	In Process	Pass & Ongoing	
		Progress Reporting	N/A	N/A	In Process	Pass & Ongoing	
Total							**1**

Section 03 Financial Sustainability

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Process Measure	AV Driving	Milestone	Required Due Date	Committed Due Date	Milestone Status	Reviewer Status	AV Awarded
Financial Stability Update		1. Finalize PPS finance structure, including reporting structure	12/31/2015	N/A	Completed	Pass & Complete	1
		2. Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	3/31/2016	N/A	Completed	Pass & Complete	
		3. Finalize Compliance Plan consistent with New York State Social Services Law 363-d	12/31/2015	N/A	Completed	Pass & Complete	
		4. Develop a Value Based Needs Assessment "VNA"	3/31/2020	N/A	Completed	Pass & Complete	
		Major Risks to Implementation & Risk Mitigation Strategies	N/A	N/A	In Process	Pass & Ongoing	
		Major Dependencies on Organizational Workstreams	N/A	N/A	In Process	Pass & Ongoing	

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Additional Financial Stability Topic Areas		Roles and Responsibilities	N/A	N/A	In Process	Pass & Ongoing	N/A
		Key Stakeholders	N/A	N/A	In Process	Pass & Ongoing	
		IT Expectations	N/A	N/A	In Process	Pass & Ongoing	
		Progress Reporting	N/A	N/A	In Process	Pass & Ongoing	
Total							**1**

Section 04 Cultural Competency & Health Literacy							
Process Measure	**AV Driving**	**Milestone**	**Required Due Date**	**Committed Due Date**	**Milestone Status**	**Reviewer Status**	**AV Awarded**
Cultural Competency /Health Literacy		1. Finalize cultural competency / health literacy strategy.	12/31/2015	N/A	Completed	Pass & Complete	1
		2. Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	6/30/2016	N/A	Completed	Pass & Complete	

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Additional Cultural Competency /Health Literacy Topic Areas	●	Major Risks to Implementation & Risk Mitigation Strategies	N/A	N/A	In Process	Pass & Ongoing	N/A
	●	Major Dependencies on Organizational Workstreams	N/A	N/A	In Process	Pass & Ongoing	
	●	Roles and Responsibilities	N/A	N/A	In Process	Pass & Ongoing	
	●	Key Stakeholders	N/A	N/A	In Process	Pass & Ongoing	
	●	IT Expectations	N/A	N/A	In Process	Pass & Ongoing	
	●	Progress Reporting	N/A	N/A	In Process	Pass & Ongoing	
Total							**1**

Section 05 IT Systems and Processes							
Process Measure	**AV Driving** ●	**Milestone**	**Required Due Date**	**Committed Due Date**	**Milestone Status**	**Reviewer Status**	**AV Awarded**

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IT Systems and Processes		1. Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s).	6/30/2016	N/A	Complete	Pass & Complete	N/A
		2. Develop an IT Change Management Strategy.	6/30/2016	N/A	Complete	Pass & Complete	
		3. Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network	3/31/2016	N/A	Complete	Pass & Complete	
		4. Develop a specific plan for engaging attributed members in Qualifying Entities	9/30/2016	N/A	Complete	Pass & Complete	
		5. Develop a data security and confidentiality plan.	6/30/2016	N/A	Complete	Pass & Complete	
		Major Risks to Implementation & Risk Mitigation Strategies	N/A	N/A	In Process	Pass & Ongoing	
		Major Dependencies on Organizational Workstreams	N/A	N/A	In Process	Pass & Ongoing	

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Achievement Value (AV) Scorecard DY3, Q2 July 1, 2017 - September 30, 2017 (Payment
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Additional IT Systems and Processes Topic Areas							
	●	Roles and Responsibilities	N/A	N/A	In Process	Pass & Ongoing	N/A
	●	Key Stakeholders	N/A	N/A	In Process	Pass & Ongoing	
	●	Progress Reporting	N/A	N/A	In Process	Pass & Ongoing	
Total							**0**

Section 06 Performance Reporting							
Process Measure	**AV Driving**	**Milestone**	**Required Due Date**	**Committed Due Date**	**Milestone Status**	**Reviewer Status**	**AV Awarded**
Performance Reporting	●	1. Establish reporting structure for PPS-wide performance reporting and communication.	9/30/2016	N/A	Complete	Pass & Complete	N/A
	●	2. Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting.	3/31/2016	N/A	Complete	Pass & Complete	N/A

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Achievement Value (AV) Scorecard DY3, Q2 July 1, 2017 - September 30, 2017 (Payment
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Additional Performance Reporting Topic Areas	●	Major Risks to Implementation & Risk Mitigation Strategies	N/A	N/A	In Process	Pass & Ongoing	N/A
	●	Major Dependencies on Organizational Workstreams	N/A	N/A	In Process	Pass & Ongoing	
	●	Roles and Responsibilities	N/A	N/A	In Process	Pass & Ongoing	
	●	Key Stakeholders	N/A	N/A	In Process	Pass & Ongoing	
	●	IT Expectations	N/A	N/A	In Process	Pass & Ongoing	
	●	Progress Reporting	N/A	N/A	In Process	Pass & Ongoing	
Total							**0**

Section 07 Practitioner Engagement							
Process Measure	**AV Driving**	**Milestone**	**Required Due Date**	**Committed Due Date**	**Milestone Status**	**Reviewer Status**	**AV Awarded**
	●	1. Develop Practitioners communication and engagement plan.	3/31/2016	N/A	Complete	Pass & Complete	

Practitioner Engagement							N/A
		2. Develop training / education plan targeting practioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda.	3/31/2016	N/A	Complete	Pass & Complete	
Additional Practitioner Engagement Topic Areas		Major Risks to Implementation & Risk Mitigation Strategies	N/A	N/A	In Process	Pass & Ongoing	N/A
		Major Dependencies on Organizational Workstreams	N/A	N/A	In Process	Pass & Ongoing	
		Roles and Responsibilities	N/A	N/A	In Process	Pass & Ongoing	
		Key Stakeholders	N/A	N/A	In Process	Pass & Ongoing	
		IT Expectations	N/A	N/A	In Process	Pass & Ongoing	
		Progress Reporting	N/A	N/A	In Process	Pass & Ongoing	

Total			**0**

Section 08 Population Health Management							
Process Measure	**AV Driving**	**Milestone**	**Required Due Date**	**Committed Due Date**	**Milestone Status**	**Reviewer Status**	**AV Awarded**
Population Health		1. Develop population health management roadmap.	6/30/2016	N/A	Complete	Pass & Complete	N/A
		2. Finalize PPS-wide bed reduction plan.	3/31/2017	N/A	Complete	Pass & Complete	N/A
Additional Population Health Topic Areas		Major Risks to Implementation & Risk Mitigation Strategies	N/A	N/A	In Process	Pass & Ongoing	N/A
		Major Dependencies on Organizational Workstreams	N/A	N/A	In Process	Pass & Ongoing	
		Roles and Responsibilities	N/A	N/A	In Process	Pass & Ongoing	
		Key Stakeholders	N/A	N/A	In Process	Pass & Ongoing	

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		IT Expectations	N/A	N/A	In Process	Pass & Ongoing	
		Progress Reporting	N/A	N/A	In Process	Pass & Ongoing	
Total							**0**

Section 09 Clinical Integration							
Process Measure	**AV Driving**	**Milestone**	**Required Due Date**	**Committed Due Date**	**Milestone Status**	**Reviewer Status**	**AV Awarded**
Clinical Integration		1. Perform a clinical integration 'needs assessment'.	N/A	N/A	In Process	Pass & Ongoing	N/A
		2. Develop a Clinical Integration strategy.	6/30/2016	N/A	Completed	Pass & Complete	N/A
		Major Risks to Implementation & Risk Mitigation Strategies	N/A	N/A	In Process	Pass & Ongoing	
		Major Dependencies on Organizational Workstreams	N/A	N/A	In Process	Pass & Ongoing	
		Roles and Responsibilities	N/A	N/A	In Process	Pass & Ongoing	

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Additional Clinical Integration Topic Areas							N/A
		Key Stakeholders	N/A	N/A	In Process	Pass & Ongoing	
		IT Expectations	N/A	N/A	In Process	Pass & Ongoing	
		Progress Reporting	N/A	N/A	In Process	Pass & Ongoing	
Total							**0**

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Achievement Value (AV) Scorecard DY3, Q2 July 1, 2017 - September 30, 2017 (Payment Quarter)
Suffolk Care Collaborative AV Adjustments

AV Adjustment Scoresheet								
Adjustment	AVs Per Project	Total Projects Selected	Total AVs Available	Total AVs Awarded		Adjusted AVs	Net AVs Awarded	
				Net Awarded	Percentage AV		Net Awarded	Percentage AV
Organizational Adjustments (applied to all projects)	5.00	11.00	55.00	55.00	100%	0.00	55.00	100%
Project Adjustments (applied to one project only)	Various	11.00	133.00	124.50	94%	0.00	124.50	94%
Total			**188.00**	**179.50**	**95%**	**0.00**	**179.50**	**95%**

Hide Reviewer Comments

☐ Organizational ☐ Project Adjustments

No AV Adjustments	
	Please note that there are no AV adjustments for Suffolk Care Collaborative in DY2, Q1

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Achievement Value (AV) Scorecard DY3, Q2 July 1, 2017 - September 30, 2017 (Payment Quarter)
Suffolk Care Collaborative - Project 2.a.i

Project Snapshot	
Project Domain	System Transformation Projects (Domain 2)
Project ID	2.a.i
Project Title	Create an Integrated Delivery System focused on Evidence Based Medicine and Population Health Management

Payment Snapshot		
DY3, Q2 Payment Available	$	1,831,542
DY3, Q2 Payment Earned	$	1,831,542

2.a.i Scoresheet

Domain	Component	Review Status	AVs Available	Net AVs Awarded	Percentage AV	Domain Funding % (DY3)	Domain Funding % (DY3, Q2)	Payment Available ($)	Net Payment Earned ($)
Domain 1	Domain 1 Organizational	Complete	5.00	5.00	100%	40%	80%	1,465,233	1,465,233
	Project Implementation Speed	N/A	0.00	0.00	0%				
	Patient Engagement Speed	N/A	0.00	0.00	0%				
Domain 1 Subtotal			**5.00**	**5.00**	**100%**	**40%**	**80%**	**1,465,233**	**1,465,233**
Domain 2	Domain 2 Pay for Reporting (P4R)	Complete	15.00	15.00	100%	10%	20%	366,308	366,308
	Domain 2 Pay for Performance (P4P)	N/A	N/A	N/A	N/A	50%	0%	-	-
Domain 2 Subtotal			**15.00**	**15.00**	**100%**	**60%**	**20%**	**366,308**	**366,308**
Total		**Complete**	**20.00**	**20.00**	**100%**	**100%**	**100%**	**1,831,542**	**1,831,542**

Total Project 2.a.i AVs Awarded: 20 out of 20

Hide Reviewer Comments

Domain 1 Project Milestones Project 2.a.i

AV Driving	Project Requirement and Metric/Deliverable	Required Due Date	Committed Due Date	Milestone Status	Reviewer Status	AVs Awarded
●	Module 1 - Major risks to implementation and mitigation strategies	Ongoing	N/A		Pass & Ongoing	N/A
	Enter Reviewer Comment					

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Suffolk Care Collaborative - Project 2.a.i

	Module 2 - Project Implementation Speed	Ongoing	N/A	In Process	Pass & Ongoing	0.00
	Enter Reviewer Comment					
Total						**0.00**

Domain 1 Project Prescribed Milestones Project 2.a.i						
AV Driving	**Project Requirement and Metric/Deliverable**	**Required Due Date**	**Committed Due Date**	**Milestone Status**	**Reviewer Status**	**AVs Awarded**
	1. All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary to support its strategy.			In Process	Pass & Ongoing	N/A
	Enter Reviewer Comment					
	2. Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.	3/31/2017	3/31/2017	In Process	Pass & Complete	N/A
	Enter Reviewer Comment					
	3. Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.	3/31/2017	3/31/2017	In Process	Pass & Complete	N/A
	Enter Reviewer Comment					
	4. Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including directed exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.			In Process	Pass & Ongoing	N/A

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Suffolk Care Collaborative - Project 2.a.i

	Enter Reviewer Comment					
●	5. Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.			In Process	Pass & Ongoing	N/A
	Enter Reviewer Comment					
●	6. Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.			In Process	Pass & Ongoing	N/A
	Enter Reviewer Comment					
●	7. Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.			In Process	Pass & Ongoing	N/A
	Enter Reviewer Comment					
●	8. Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.			In Process	Pass & Ongoing	N/A
	Enter Reviewer Comment					
●	9. Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	3/31/2017	3/31/2017	In Process	Pass & Complete	N/A
	Enter Reviewer Comment					
●	10. Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.			In Process	Pass & Ongoing	N/A
	Enter Reviewer Comment					

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Suffolk Care Collaborative - Project 2.a.i

	11. Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as			In Process	Pass & Ongoing	N/A
	Enter Reviewer Comment					
Total						**0.00**

Domain 2 Pay for Performance and Pay for Reporting Project 2.a.i			
AV Driving	**Measure**	**Reviewer Status**	**AVs Awarded**
	Adult Access to Preventive or Ambulatory Care - 20 to 44 years	Pass & Ongoing	0.3333333
	Enter Reviewer Comment		
	Adult Access to Preventive or Ambulatory Care - 45 to 64 years	Pass & Ongoing	0.3333333
	Enter Reviewer Comment		
	Adult Access to Preventive or Ambulatory Care - 65 and older	Pass & Ongoing	0.3333333
	Enter Reviewer Comment		
	CAHPS Measures - Care Coordination with provider up-to-date about care received from other providers	Pass & Ongoing	1
	Enter Reviewer Comment		
	Children's Access to Primary Care- 12 to 24 months	Pass & Ongoing	0.25
	Enter Reviewer Comment		

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●	Children's Access to Primary Care- 25 months to 6 years	Pass & Ongoing	0.25
	Enter Reviewer Comment		
●	Children's Access to Primary Care- 7 to 11 years	Pass & Ongoing	0.25
	Enter Reviewer Comment		
●	Children's Access to Primary Care- 12 to 19 years	Pass & Ongoing	0.25
	Enter Reviewer Comment		
●	Getting Timely Appointments, Care and information (Q6, 8, 10, and 12)	Pass & Ongoing	0.5
	Enter Reviewer Comment		
●	Helpful, Courteous, and Respectful Office Staff (Q24 and 25)	Pass & Ongoing	0.5
	Enter Reviewer Comment		
●	H-CAHPS – Care Transition Metrics	Pass & Ongoing	1
	Enter Reviewer Comment		
●	Medicaid Spending on ER and Inpatient Services ±	Pass & Ongoing	1
	Enter Reviewer Comment		
●	Medicaid spending on Primary Care and community based behavioral health care	Pass & Ongoing	1

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	Enter Reviewer Comment		
	PDI 90– Composite of all measures +/-	Pass & Ongoing	1
	Enter Reviewer Comment		
	Percent of eligible providers with participating agreements with RHIOs, meeting Meaningful Use criteria and able to participate in bidirectional exchange	Pass & Ongoing	1
	Enter Reviewer Comment		
	Percent of PCP meeting PCMH (NCQA) or Advance Primary Care (SHIP) standards	Pass & Ongoing	1
	Enter Reviewer Comment		
	Percent of total Medicaid provider reimbursement received through sub-capitation or other forms of non-FFS reimbursement	Pass & Ongoing	1
	Enter Reviewer Comment		
	Potentially Avoidable Emergency Room Visits	Pass & Ongoing	1
	Enter Reviewer Comment		
	Potentially Avoidable Readmissions	Pass & Ongoing	1
	Enter Reviewer Comment		
	PQI 90 – Composite of all measures +/-	Pass & Ongoing	1
	Enter Reviewer Comment		

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●	Primary Care - Length of Relationship - Q3	Pass & Ongoing	0.5
	Enter Reviewer Comment		
●	Primary Care - Usual Source of Care - Q2	Pass & Ongoing	0.5
	Enter Reviewer Comment		
Total			**15.00**

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Achievement Value (AV) Scorecard DY3, Q2 July 1, 2017 - September 30, 2017 (Payment Quarter)
Suffolk Care Collaborative - Project 2.b.iv

Project Snapshot	
Project Domain	System Transformation Projects (Domain 2)
Project ID	2.b.iv
Project Title	Care transitions intervention patients with a care transition plan developed prior to discharge.

Payment Snapshot		
DY3, Q2 Payment Available	$	1,406,362
DY3, Q2 Payment Earned	$	1,406,362

2.b.iv Scoresheet

Domain	Component	Review Status	AVs Available	Net AVs Awarded	Percentage AV	Domain Funding % (DY3)	Domain Funding % (DY3, Q2)	Payment Available ($)	Net Payment Earned ($)
Domain 1	Domain 1 Organizational	Complete	5.00	5.00	100%	40%	80%	1,125,090	1,125,090
	Project Implementation Speed	N/A	0.00	0.00	0%				
	Patient Engagement Speed	Complete	1.00	1.00	100%				
Domain 1 Subtotal			**6.00**	**6.00**	**100%**	**40%**	**80%**	**1,125,090**	**1,125,090**
Domain 2	Domain 2 Pay for Reporting (P4R)	Complete	15.00	15.00	100%	10%	20%	281,272	281,272
	Domain 2 Pay for Performance (P4P)	N/A	N/A	N/A	N/A	50%	0%	-	-
Domain 2 Subtotal			**15.00**	**15.00**	**100%**	**60%**	**20%**	**281,272**	**281,272**
Total		**Complete**	**21.00**	**21.00**	**100%**	**100%**	**100%**	**1,406,362**	**1,406,362**

Total Project 2.b.iv AVs Awarded: 21 out of 21

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Domain 1 Project Milestones Project 2.b.iv

AV Driving	Project Requirement and Metric/Deliverable	Required Due Date	Committed Due Date	Milestone Status	Reviewer Status	AVs Awarded
	Module 1 - Major risks to implementation and mitigation strategies	Ongoing	N/A	In Process	Pass & Ongoing	N/A

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Achievement Value (AV) Scorecard DY3, Q2 July 1, 2017 - September 30, 2017 (Payment Quarter)
Suffolk Care Collaborative - Project 2.b.iv

	Enter Reviewer Comment					
	Module 2 - Project Implementation Speed	3/31/2017	3/31/2017	Completed	Pass & Complete	0.00
	Enter Reviewer Comment					
	Module 3 - Patient Engagement Speed	Ongoing	N/A	In Process	Pass & Ongoing	1
	Enter Reviewer Comment					
Total						**1.00**

Domain 1 Project Prescribed Milestones Project 2.b.iv						
AV Driving	**Project Requirement and Metric/Deliverable**	**Required Due Date**	**Committed Due Date**	**Milestone Status**	**Reviewer Status**	**AVs Awarded**
	1. Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
	2. Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
	3. Ensure required social services participate in the project.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					

●	4. Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
●	5. Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
●	6. Ensure that a 30-day transition of care period is established.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
●	7. Use EHRs and other technical platforms to track all patients engaged in the project.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
Total						**0.00**

Domain 2 Pay for Performance and Pay for Reporting Project 2.b.iv (all Milestones are P4R in DY2)			
AV Driving	**Measure**	**Reviewer Status**	**AVs Awarded**
●	Adult Access to Preventive or Ambulatory Care - 20 to 44 years	Pass & Ongoing	0.3333333
	Enter Reviewer Comment		
Domain 2 Pay for Performance and	Adult Access to Preventive or Ambulatory Care - 45 to 64 years	Pass & Ongoing	0.3333333
	Enter Reviewer Comment		

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Achievement Value (AV) Scorecard DY3, Q2 July 1, 2017 - September 30, 2017 (Payment Quarter)
Suffolk Care Collaborative - Project 2.b.iv

●	Adult Access to Preventive or Ambulatory Care - 65 and older	Pass & Ongoing	0.3333333
	Enter Reviewer Comment		
●	CAHPS Measures - Care Coordination with provider up-to-date about care received from other providers	Pass & Ongoing	1
	Enter Reviewer Comment		
●	Children's Access to Primary Care- 12 to 19 years	Pass & Ongoing	0.25
	Enter Reviewer Comment		
●	Children's Access to Primary Care- 12 to 24 months	Pass & Ongoing	0.25
	Enter Reviewer Comment		
●	Children's Access to Primary Care- 25 months to 6 years	Pass & Ongoing	0.25
	Enter Reviewer Comment		
●	Children's Access to Primary Care- 7 to 11 years	Pass & Ongoing	0.25
	Enter Reviewer Comment		
●	Getting Timely Appointments, Care and information (Q6, 8, 10, and 12)	Pass & Ongoing	0.5
	Enter Reviewer Comment		
●	Helpful, Courteous, and Respectful Office Staff (Q24 and 25)	Pass & Ongoing	0.5

	Enter Reviewer Comment		
	H-CAHPS – Care Transition Metrics	Pass & Ongoing	1
	Enter Reviewer Comment		
	Medicaid Spending on ER and Inpatient Services ±	Pass & Ongoing	1
	Enter Reviewer Comment		
	Medicaid spending on Primary Care and community based behavioral health care	Pass & Ongoing	1
	Enter Reviewer Comment		
	PDI 90– Composite of all measures +/-	Pass & Ongoing	1
	Enter Reviewer Comment		
	Percent of eligible providers with participating agreements with RHIOs, meeting Meaningful Use criteria and able to participate in bidirectional exchange	Pass & Ongoing	1
	Enter Reviewer Comment		
	Percent of PCP meeting PCMH (NCQA) or Advance Primary Care (SHIP) standards	Pass & Ongoing	1
	Enter Reviewer Comment		
	Percent of total Medicaid provider reimbursement received through sub-capitation or other forms of non-FFS reimbursement	Pass & Ongoing	1
	Enter Reviewer Comment		

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Suffolk Care Collaborative - Project 2.b.iv

	Potentially Avoidable Emergency Room Visits	Pass & Ongoing	1
	Enter Reviewer Comment		
	Potentially Avoidable Readmissions	Pass & Ongoing	1
	Enter Reviewer Comment		
	PQI 90 – Composite of all measures +/-	Pass & Ongoing	1
	Enter Reviewer Comment		
	Primary Care - Length of Relationship - Q3	Pass & Ongoing	0.5
	Enter Reviewer Comment		
	Primary Care - Usual Source of Care - Q2	Pass & Ongoing	0.5
	Enter Reviewer Comment		
Total			**15.00**

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Achievement Value (AV) Scorecard DY3, Q2 July 1, 2017 - September 30, 2017 (Payment Quarter)
Suffolk Care Collaborative - Project 2.b.ix

Project Snapshot	
Project Domain	System Transformation Projects (Domain 2)
Project ID	2.b.ix
Project Title	Implementation of observational programs in hospitals

Payment Snapshot		
DY3, Q2 Payment Available	$	1,177,420
DY3, Q2 Payment Earned	$	1,042,857

2.b.ix Scoresheet

Domain	Component	Review Status	AVs Available	Net AVs Awarded	Percentage AV	Domain Funding % (DY3)	Domain Funding % (DY3, Q2)	Payment Available ($)	Net Payment Earned ($)
Domain 1	Domain 1 Organizational	Complete	5.00	5.00	100%	40%	80%	941,936	807,373
	Project Implementation Speed	Complete	1.00	1.00	100%				
	Patient Engagement Speed	Complete	1.00	0.00	0%				
Domain 1 Subtotal			**7.00**	**6.00**	**86%**	**40%**	**80%**	**941,936**	**807,373**
Domain 2	Domain 2 Pay for Reporting (P4R)	Complete	15.00	15.00	100%	10%	20%	235,484	235,484
	Domain 2 Pay for Performance (P4P)	N/A	N/A	N/A	N/A	50%	0%	-	-
Domain 2 Subtotal			**15.00**	**15.00**	**100%**	**60%**	**20%**	**235,484**	**235,484**
Total		**Complete**	**22.00**	**21.00**	**95%**	**100%**	**100%**	**1,177,420**	**1,042,857**

Total Project 2.b.ix AVs Awarded: 21 out of 22

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Domain 1 Project Milestones Project 2.b.ix

AV Driving	Project Requirement and Metric/Deliverable	Required Due Date	Committed Due Date	Milestone Status	Reviewer Status	AVs Awarded
	Module 1 - Major risks to implementation and mitigation strategies	Ongoing	N/A	In Process	Pass & Ongoing	N/A

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Achievement Value (AV) Scorecard DY3, Q2 July 1, 2017 - September 30, 2017 (Payment Quarter)
Suffolk Care Collaborative - Project 2.b.ix

	Enter Reviewer Comment					
	Module 2 - Project Implementation Speed	Ongoing	N/A	In Process	Pass & Ongoing	1.00
	Enter Reviewer Comment					
	Module 3 - Patient Engagement Speed	Ongoing	N/A	In Process	Fail	0
	Enter Reviewer Comment					
Total						**1.00**

Domain 1 Project Prescribed Milestones Project 2.b.ix						
AV Driving	**Project Requirement and Metric/Deliverable**	**Required Due Date**	**Committed Due Date**	**Milestone Status**	**Reviewer Status**	**AVs Awarded**
	1. Establish appropriately sized and staffed observation (OBS) units in close proximity to ED services, unless the services required are better provided in another unit. When the latter occurs, care coordination must still be provided.	9/30/2017	9/30/2017	Completed	Pass & Complete	0.33
	Enter Reviewer Comment					
	2. Create clinical and financial model to support the need for the unit.	9/30/2017	9/30/2017	Completed	Pass & Complete	0.33
	Enter Reviewer Comment					
	3. Utilize care coordination services to ensure safe discharge either to the community or a step down level of service, such as behavioral health or assisted living/SNF.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					

	4. Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including Direct exchange (secure messaging), alerts and patient record look up by the end of Demonstration Year (DY) 3.	9/30/2017	9/30/2017	Completed	Pass & Complete	0.33
	Enter Reviewer Comment					
	5. Use EHRs and other technical platforms to track all patients engaged in the project.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
Total						**1.00**

Domain 2 Pay for Performance and Pay for Reporting Project 2.b.ix			
AV Driving	**Measure**	**Reviewer Status**	**AVs Awarded**
	Adult Access to Preventive or Ambulatory Care - 20 to 44 years	Pass & Ongoing	0.3333333
	Enter Reviewer Comment		
	Adult Access to Preventive or Ambulatory Care - 45 to 64 years	Pass & Ongoing	0.3333333
	Enter Reviewer Comment		
	Adult Access to Preventive or Ambulatory Care - 65 and older	Pass & Ongoing	0.3333333
	Enter Reviewer Comment		
Domain 2 Pay for	CAHPS Measures - Care Coordination with provider up-to-date about care received from other providers	Pass & Ongoing	1

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Achievement Value (AV) Scorecard DY3, Q2 July 1, 2017 - September 30, 2017 (Payment Quarter)
Suffolk Care Collaborative - Project 2.b.ix

Performance and			
	Enter Reviewer Comment		
●	Children's Access to Primary Care- 12 to 19 years	Pass & Ongoing	0.25
	Enter Reviewer Comment		
●	Children's Access to Primary Care- 12 to 24 months	Pass & Ongoing	0.25
	Enter Reviewer Comment		
●	Children's Access to Primary Care- 25 months to 6 years	Pass & Ongoing	0.25
	Enter Reviewer Comment		
●	Children's Access to Primary Care- 7 to 11 years	Pass & Ongoing	0.25
	Enter Reviewer Comment		
●	Getting Timely Appointments, Care and information (Q6, 8, 10, and 12)	Pass & Ongoing	0.5
	Enter Reviewer Comment		
●	Helpful, Courteous, and Respectful Office Staff (Q24 and 25)	Pass & Ongoing	0.5
	Enter Reviewer Comment		
●	H-CAHPS – Care Transition Metrics	Pass & Ongoing	1
	Enter Reviewer Comment		

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	Medicaid Spending on ER and Inpatient Services ±	Pass & Ongoing	1
	Enter Reviewer Comment		
	Medicaid spending on Primary Care and community based behavioral health care	Pass & Ongoing	1
	Enter Reviewer Comment		
	PDI 90– Composite of all measures +/-	Pass & Ongoing	1
	Enter Reviewer Comment		
	Percent of eligible providers with participating agreements with RHIOs, meeting Meaningful Use criteria and able to participate in bidirectional exchange	Pass & Ongoing	1
	Enter Reviewer Comment		
	Percent of PCP meeting PCMH (NCQA) or Advance Primary Care (SHIP) standards	Pass & Ongoing	1
	Enter Reviewer Comment		
	Percent of total Medicaid provider reimbursement received through sub-capitation or other forms of non-FFS reimbursement	Pass & Ongoing	1
	Enter Reviewer Comment		
	Potentially Avoidable Emergency Room Visits	Pass & Ongoing	1
	Enter Reviewer Comment		
	Potentially Avoidable Readmissions	Pass & Ongoing	1

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Suffolk Care Collaborative - Project 2.b.ix

	Enter Reviewer Comment		
	PQI 90 – Composite of all measures +/-	Pass & Ongoing	1
	Enter Reviewer Comment		
	Primary Care - Length of Relationship - Q3	Pass & Ongoing	0.5
	Enter Reviewer Comment		
	Primary Care - Usual Source of Care - Q2	Pass & Ongoing	0.5
	Enter Reviewer Comment		
Total			**15.00**

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Achievement Value (AV) Scorecard DY3, Q2 July 1, 2017 - September 30, 2017 (Payment Quarter)
Suffolk Care Collaborative - Project 2.b.vii

Project Snapshot	
Project Domain	System Transformation Projects (Domain 2)
Project ID	2.b.vii
Project Title	Implementing the INTERACT project (inpatient transfer avoidance program for SNF)

Payment Snapshot		
DY3, Q2 Payment Available	$	1,340,950
DY3, Q2 Payment Earned	$	1,340,950

2.b.vii Scoresheet

Domain	Component	Review Status	AVs Available	Net AVs Awarded	Percentage AV	Domain Funding % (DY3)	Domain Funding % (DY3, Q2)	Payment Available ($)	Net Payment Earned ($)
Domain 1	Domain 1 Organizational	Complete	5.00	5.00	100%	40%	80%	1,072,760	1,072,760
	Project Implementation Speed	N/A	0.00	0.00	0%				
	Patient Engagement Speed	Complete	1.00	1.00	100%				
Domain 1 Subtotal			**6.00**	**6.00**	**100%**	**40%**	**80%**	**1,072,760**	**1,072,760**
Domain 2	Domain 2 Pay for Reporting (P4R)	Complete	15.00	15.00	100%	10%	20%	268,190	268,190
	Domain 2 Pay for Performance (P4P)	N/A	N/A	N/A	N/A	50%	0%	-	-
Domain 2 Subtotal			**15.00**	**15.00**	**100%**	**60%**	**20%**	**268,190**	**268,190**
Total		**Complete**	**21.00**	**21.00**	**100%**	**100%**	**100%**	**1,340,950**	**1,340,950**

Total Project 2.b.vii AVs Awarded: 21 out of 21

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Domain 1 Project Milestones Project 2.b.vii

AV Driving	Project Requirement and Metric/Deliverable	Required Due Date	Committed Due Date	Milestone Status	Reviewer Status	AVs Awarded
	Module 1 - Major risks to implementation and mitigation strategies	Ongoing	N/A	In Process	Pass & Ongoing	N/A

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Suffolk Care Collaborative - Project 2.b.vii

	Enter Reviewer Comment					
	Module 2 - Project Implementation Speed	3/31/2017	3/31/2017	Completed	Pass & Ongoing	0.00
	Enter Reviewer Comment					
	Module 3 - Patient Engagement Speed	Ongoing	N/A	In Process	Pass & Ongoing	1
	Enter Reviewer Comment					
Total						**1.00**

Domain 1 Project Prescribed Milestones Project 2.b.vii						
AV Driving	**Project Requirement and Metric/Deliverable**	**Required Due Date**	**Committed Due Date**	**Milestone Status**	**Reviewer Status**	**AVs Awarded**
	1. Implement INTERACT at each participating SNF, demonstrated by active use of the INTERACT 3.0 toolkit and other resources available at http://interact2.net.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
	2. Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
	3. Implement care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
	4. Educate all staff on care pathways and INTERACT principles.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A

	Enter Reviewer Comment					
	5. Implement Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
	6. Create coaching program to facilitate and support implementation.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
	7. Educate patient and family/caretakers, to facilitate participation in planning of care.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
	8. Establish enhanced communication with acute care hospitals, preferably with EHR and HIE connectivity.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
	9. Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
	10. Use EHRs and other technical platforms to track all patients engaged in the project.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
Domain 2 Pay for Performance and Pay for Reporting - Project 2.b.vii						**0.00**

Domain 2 Pay for Performance and Pay for Reporting

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Suffolk Care Collaborative - Project 2.b.vii

AV Driving	Measure	Reviewer Status	AVs Awarded
●	Adult Access to Preventive or Ambulatory Care - 20 to 44 years	Pass & Ongoing	0.3333333
	Enter Reviewer Comment		
●	Adult Access to Preventive or Ambulatory Care - 45 to 64 years	Pass & Ongoing	0.3333333
	Enter Reviewer Comment		
●	Adult Access to Preventive or Ambulatory Care - 65 and older	Pass & Ongoing	0.3333333
	Enter Reviewer Comment		
●	CAHPS Measures - Care Coordination with provider up-to-date about care received from other providers	Pass & Ongoing	1
	Enter Reviewer Comment		
●	Children's Access to Primary Care- 12 to 19 years	Pass & Ongoing	0.25
	Enter Reviewer Comment		
●	Children's Access to Primary Care- 12 to 24 months	Pass & Ongoing	0.25
	Enter Reviewer Comment		
●	Children's Access to Primary Care- 25 months to 6 years	Pass & Ongoing	0.25
	Enter Reviewer Comment		

	Children's Access to Primary Care- 7 to 11 years	Pass & Ongoing	0.25
	Enter Reviewer Comment		
	Getting Timely Appointments, Care and information (Q6, 8, 10, and 12)	Pass & Ongoing	0.5
	Enter Reviewer Comment		
	Helpful, Courteous, and Respectful Office Staff (Q24 and 25)	Pass & Ongoing	0.5
	Enter Reviewer Comment		
	H-CAHPS – Care Transition Metrics	Pass & Ongoing	1
	Enter Reviewer Comment		
	Medicaid Spending on ER and Inpatient Services ±	Pass & Ongoing	1
	Enter Reviewer Comment		
	Medicaid spending on Primary Care and community based behavioral health care	Pass & Ongoing	1
	Enter Reviewer Comment		
	PDI 90– Composite of all measures +/-	Pass & Ongoing	1
	Enter Reviewer Comment		
	Percent of eligible providers with participating agreements with RHIOs, meeting Meaningful Use criteria and able to participate in bidirectional exchange	Pass & Ongoing	1

	Enter Reviewer Comment		
	Percent of PCP meeting PCMH (NCQA) or Advance Primary Care (SHIP) standards	Pass & Ongoing	1
	Enter Reviewer Comment		
	Percent of total Medicaid provider reimbursement received through sub-capitation or other forms of non-FFS reimbursement	Pass & Ongoing	1
	Enter Reviewer Comment		
	Potentially Avoidable Emergency Room Visits	Pass & Ongoing	1
	Enter Reviewer Comment		
	Potentially Avoidable Readmissions	Pass & Ongoing	1
	Enter Reviewer Comment		
	PQI 90 – Composite of all measures +/-	Pass & Ongoing	1
	Enter Reviewer Comment		
	Primary Care - Length of Relationship - Q3	Pass & Ongoing	0.5
	Enter Reviewer Comment		
	Primary Care - Usual Source of Care - Q2	Pass & Ongoing	0.5
	Enter Reviewer Comment		
Total			**15.00**

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Achievement Value (AV) Scorecard DY3, Q2 July 1, 2017 - September 30, 2017 (Payment Quarter)
Suffolk Care Collaborative - Project 2.d.i

Project Snapshot	
Project Domain	System Transformation Projects (Domain 2)
Project ID	2.d.i
Project Title	Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into

Payment Snapshot		
DY3, Q2 Payment Available	$	1,279,694
DY3, Q2 Payment Earned	$	1,279,694

2.d.i Scoresheet

Domain	Component	Review Status	AVs Available	Net AVs Awarded	Percentage AV	Domain Funding % (DY3)	Domain Funding % (DY3, Q2)	Payment Available ($)	Net Payment Earned ($)
Domain 1	Domain 1 Organizational	Complete	5.00	5.00	100%	40%	80%	1,023,755	1,023,755
	Project Implementation Speed	N/A	0.00	0.00	0%				
	Patient Engagement Speed	Complete	1.00	1.00	100%				
Domain 1 Subtotal			**6.00**	**6.00**	**100%**	**40%**	**80%**	**1,023,755**	**1,023,755**
Domain 2	Domain 2 Pay for Reporting (P4R)	Complete	4.00	4.00	100%	10%	20%	255,939	255,939
	Domain 2 Pay for Performance (P4P)	N/A	N/A	N/A	N/A	50%	0%	-	-
Domain 2 Subtotal			**4.00**	**4.00**	**100%**	**60%**	**20%**	**255,939**	**255,939**
Total		**Complete**	**10.00**	**10.00**	**100%**	**100%**	**100%**	**1,279,694**	**1,279,694**

Total Project 2.d.i AVs Awarded: 10 out of 10

Hide Reviewer Comments

Domain 1 Project Milestones Project 2.d.i

AV Driving	Project Requirement and Metric/Deliverable	Required Due Date	Committed Due Date	Milestone Status	Reviewer Status	AVs Awarded
	Module 1 - Major risks to implementation and mitigation strategies	Ongoing	N/A	In Process	Pass & Ongoing	N/A

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	Enter Reviewer Comment					
	Module 2 - Project Implementation Speed	Ongoing	N/A	In Process	Pass & Ongoing	0.00
	Module 3 - Patient Engagement Speed	Ongoing	N/A	In Process	Pass & Ongoing	1
	Enter Reviewer Comment					
Total						**1.00**

Domain 1 Project Prescribed Milestones Project 2.d.i						
AV Driving	**Project Requirement and Metric/Deliverable**	**Required Due Date**	**Committed Due Date**	**Milestone Status**	**Reviewer Status**	**AVs Awarded**
	1. Contract or partner with community-based organizations (CBOs) to engage target populations using PAM® and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.			Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
	2. Establish a PPS-wide training team, comprised of members with training in PAM® and expertise in patient activation and engagement.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
	3. Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					

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Suffolk Care Collaborative - Project 2.d.i

●	4. Survey the targeted population about healthcare needs in the PPS' region.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
●	5. Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.			Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
●	6. Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10).	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
●	7. Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM® during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.			Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
●	8. Include beneficiaries in development team to promote preventive care.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
●	9. Measure PAM® components			Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
●	10. Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.			Completed	Pass & Complete	N/A

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Suffolk Care Collaborative - Project 2.d.i

	Enter Reviewer Comment					
Domain 2 Pay for Performance and Pay for Reporting	11. Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.			Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
	12. Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
	13. Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM®.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
	14. Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and			Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
	15. Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.			Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
	16. Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.			Completed	Pass & Complete	N/A
	Enter Reviewer Comment					

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Suffolk Care Collaborative - Project 2.d.i

●	17. Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
Total						**0.00**

Domain 2 Pay for Performance and Pay for Reporting Project 2.d.i (all Milestones are P4R in DY2)			
AV Driving	**Measure**	**Reviewer Status**	**AVs Awarded**
●	C&G CAHPS by PPS for uninsured- Getting timely appointments, care, and information	Pass & Ongoing	0.25
	Enter Reviewer Comment		
●	C&G CAHPS by PPS for uninsured- Patients' rating of the provider (or doctor)	Pass & Ongoing	0.25
	Enter Reviewer Comment		
●	C&G CAHPS by PPS for uninsured- How well providers (or doctors) communicate with patients	Pass & Ongoing	0.25
	Enter Reviewer Comment		
●	C&G CAHPS by PPS for uninsured- Helpful, courteous, and respectful office staff	Pass & Ongoing	0.25
	Enter Reviewer Comment		
●	ED use by uninsured	Pass & Ongoing	1
	Enter Reviewer Comment		

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●	PAM Level	Pass & Ongoing	1
	Enter Reviewer Comment		
●	Use of primary and preventive care services-- Percent of attributed Medicaid members with no claims history for primary care and preventive services in measurement year compared to same in baseline year	Pass & Ongoing	1
	Enter Reviewer Comment		
Total			**4.00**

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Achievement Value (AV) Scorecard DY3, Q2 July 1, 2017 - September 30, 2017 (Payment Quarter)
Suffolk Care Collaborative - Project 3.a.i

Project Snapshot	
Project Domain	Clinical Improvement Projects (Domain 3)
Project ID	3.a.i
Project Title	Integration of primary care and behavioral health services

Payment Snapshot		
DY3, Q2 Payment Available	$	2,551,076
DY3, Q2 Payment Earned	$	1,674,143

3.a.i Scoresheet

Domain	Component	Review Status	AVs Available	Net AVs Awarded	Percentage AV	Domain Funding % (DY3)	Domain Funding % (DY3, Q2)	Payment Available ($)	Net Payment Earned ($)
Domain 1	Domain 1 Organizational	Complete	5.00	5.00	100%	40%	40%	1,020,430	1,020,430
	Project Implementation Speed	N/A	0.00	0.00	0%				
	Patient Engagement Speed	Complete	1.00	1.00	100%				
Domain 1 Subtotal			**6.00**	**6.00**	**100%**	**40%**	**40%**	**1,020,430**	**1,020,430**
Domain 3	Domain 3 Pay for Reporting (P4R)	Complete	2.00	2.00	100%	10%	10%	255,108	255,108
	Domain 3 Pay for Performance		8.00	2.50	31%	50%	50%	1,275,538	398,606
Domain 3 Subtotal			**10.00**	**4.50**	**45%**	**60%**	**60%**	**1,530,645**	**653,713**
Total		**Complete**	**16.00**	**10.50**	**66%**	**100%**	**100%**	**2,551,076**	**1,674,143**

Total Project 3.a.i AVs Awarded: 10.5 out of 16

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Domain 1 Project Milestones Project 3.a.i

AV Driving	Project Requirement and Metric/Deliverable	Required Due Date	Committed Due Date	Milestone Status	Reviewer Status	AVs Awarded
	Module 1 - Major risks to implementation and mitigation strategies	Ongoing	N/A	In Process	Pass & Ongoing	N/A

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Achievement Value (AV) Scorecard DY3, Q2 July 1, 2017 - September 30, 2017 (Payment Quarter)
Suffolk Care Collaborative - Project 3.a.i

	Enter Reviewer Comment					
	Module 2 - Project Implementation Speed	Ongoing	N/A	In Process	Pass & Ongoing	0.00
	Enter Reviewer Comment					
	Module 3 - Patient Engagement Speed	Ongoing	N/A	In Process	Pass & Ongoing	1
	Enter Reviewer Comment					
Total						**1**

Domain 1 Project Prescribed Milestones Project 3.a.i Models 1, 2 and 3

☑ 3.a.i Model 1 ☑ 3.a.i Model 2 ☑ 3.a.i Model 3

Model	AV Driving	Project Requirement and Metric/Deliverable	Required Due Date	Committed Due Date	Milestone Status	Reviewer Status	AVs Awarded
3.a.i Model 1		1. Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.			In Process	Pass & Ongoing	N/A
		Enter Reviewer Comment					
		2. Develop collaborative evidence-based standards of care including medication management and care engagement process.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
		Enter Reviewer Comment					

		3. Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.			In Process	Pass & Ongoing	N/A
		Enter Reviewer Comment					
		4. Use EHRs or other technical platforms to track all patients engaged in this project.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
		Enter Reviewer Comment					
3.a.i Model 2		5. Co-locate primary care services at behavioral health sites.			In Process	Pass & Ongoing	N/A
		Enter Reviewer Comment					
		6. Develop collaborative evidence-based standards of care including medication management and care engagement process.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
		Enter Reviewer Comment					
		7. Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.			In Process	Pass & Ongoing	N/A
		Enter Reviewer Comment					
		8. Use EHRs or other technical platforms to track all patients engaged in this project.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
		Enter Reviewer Comment					
		9. Implement IMPACT Model at Primary Care Sites.			In Process	Pass & Ongoing	N/A

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Achievement Value (AV) Scorecard DY3, Q2 July 1, 2017 - September 30, 2017 (Payment Quarter)
Suffolk Care Collaborative - Project 3.a.i

3.a.i Model 3		*Enter Reviewer Comment*					
		10. Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
		Enter Reviewer Comment					
		11. Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
		Enter Reviewer Comment					
		12. Designate a Psychiatrist meeting requirements of the IMPACT Model.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
		Enter Reviewer Comment					
		13. Measure outcomes as required in the IMPACT Model.			In Process	Pass & Ongoing	N/A
		Enter Reviewer Comment					
		14. Provide "stepped care" as required by the IMPACT Model.			In Process	Pass & Ongoing	N/A
		Enter Reviewer Comment					
		15. Use EHRs or other technical platforms to track all patients engaged in this project.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
		Enter Reviewer Comment					
Total							**0**

Domain 3 Pay for Performance and Pay for Reporting

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Suffolk Care Collaborative - Project 3.a.i

AV Driving	Measure	Reviewer Status	AVs Awarded
●	Adherence to Antipsychotic Medications for People with Schizophrenia	Pass & Ongoing	1
	P4P Measure DY3Q2		
●	Antidepressant Medication Management - Effective Acute Phase Treatment	Fail	0
	P4P Measure DY3Q2		
●	Antidepressant Medication Management - Effective Continuation Phase Treatment	Fail	0
	P4P Measure DY3Q2		
●	Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	Fail	0
	P4P Measure DY3Q2		
●	Diabetes Monitoring for People with Diabetes and Schizophrenia	Fail	0
	P4P Measure DY3Q2		
●	Diabetes Screening for People with Schizophrenia or Bipolar Disease who are Using Antipsychotic Medication	Fail	0
	P4P Measure DY3Q2		
●	Follow-up after hospitalization for Mental Illness - within 30 days	Fail	0
	P4P Measure DY3Q2		

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Suffolk Care Collaborative - Project 3.a.i

●	Follow-up after hospitalization for Mental Illness - within 7 days	Fail	0
	P4P Measure DY3Q2		
●	Follow-up care for Children Prescribed ADHD Medications - Continuation Phase	Pass & Ongoing	0.5
	P4R Measure DY3Q2		
●	Follow-up care for Children Prescribed ADHD Medications - Initiation Phase	Pass & Ongoing	0.5
	P4R Measure DY3Q2		
●	Engagement of Alcohol and Other Drug Dependence Treatment (initiation and 2 visits within 44 days)	Pass & Ongoing	0.5
	P4P Measure DY3Q2		
●	Initiation of Alcohol and Other Drug Dependence Treatment (1 visit within 14 days)	Fail	0
	P4P Measure DY3Q2		
●	Potentially Preventable Emergency Department Visits (for persons with BH diagnosis) ±	Pass & Ongoing	1
	P4P Measure DY3Q2		
●	Screening for Clinical Depression and follow-up	Pass & Ongoing	1
	P4R Measure DY3Q2		
Total			**4.50**

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Achievement Value (AV) Scorecard DY3, Q2 July 1, 2017 - September 30, 2017 (Payment Quarter)
Suffolk Care Collaborative - Project 3.b.i

Project Snapshot	
Project Domain	Clinical Improvement Projects (Domain 3)
Project ID	3.b.i
Project Title	Evidence-based strategies for disease management in high risk/affected populations. (adult only)

Payment Snapshot		
DY3, Q2 Payment Available	$	1,942,396
DY3, Q2 Payment Earned	$	1,812,903

3.b.i Scoresheet

Domain	Component	Review Status	AVs Available	Net AVs Awarded	Percentage AV	Domain Funding % (DY3)	Domain Funding % (DY3, Q2)	Payment Available ($)	Net Payment Earned ($)
Domain 1	Domain 1 Organizational	Complete	5.00	5.00	100%	40%	40%	776,959	647,465
	Project Implementation Speed	N/A	0.00	0.00	0%				
	Patient Engagement Speed	Complete	1.00	0.00	0%				
Domain 1 Subtotal			**6.00**	**5.00**	**83%**	**40%**	**40%**	**776,959**	**647,465**
Domain 3	Domain 3 Pay for Reporting (P4R)	Complete	8.00	8.00	100%	10%	60%	1,165,438	1,165,438
	Domain 3 Pay for Performance (P4P)		0.00	0.00	N/A	50%	0%	-	-
Domain 3 Subtotal			**8.00**	**8.00**	**100%**	**60%**	**60%**	**1,165,438**	**1,165,438**
Total		**Complete**	**14.00**	**13.00**	**93%**	**100%**	**100%**	**1,942,396**	**1,812,903**

Total Project 3.b.i AVs Awarded: 13 out of 14

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Domain 1 Project Milestones Project 3.b.i

AV Driving	Project Requirement and Metric/Deliverable	Required Due Date	Committed Due Date	Milestone Status	Reviewer Status	AVs Awarded
	Module 1 - Major risks to implementation and mitigation strategies	Ongoing	N/A	In Process	Pass & Ongoing	N/A

	Enter Reviewer Comment					
	Module 2 - Project Implementation Speed	Ongoing	N/A	In Process	Pass & Ongoing	0.00
	Enter Reviewer Comment					
	Module 3 - Patient Engagement Speed	Ongoing	N/A	In Process	Fail	0
	Enter Reviewer Comment					
Total						**0.00**

Domain 1 Project Prescribed Milestones Project 3.b.i						
AV Driving	**Project Requirement and Metric/Deliverable**	**Required Due Date**	**Committed Due Date**	**Milestone Status**	**Reviewer Status**	**AVs Awarded**
	1. Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.			In Process	Pass & Ongoing	N/A
	Enter Reviewer Comment					
	2. Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.			In Process	Pass & Ongoing	N/A
	Enter Reviewer Comment					
	3. Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.			In Process	Pass & Ongoing	N/A
	Enter Reviewer Comment					

●	4. Use EHRs or other technical platforms to track all patients engaged in this project.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
●	5. Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).			In Process	Pass & Ongoing	N/A
	Enter Reviewer Comment					
●	6. Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
●	7. Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
●	8. Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.			In Process	Pass & Ongoing	N/A
	Enter Reviewer Comment					
●	9. Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
●	10. Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.			In Process	Pass & Ongoing	N/A
	Enter Reviewer Comment					

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Suffolk Care Collaborative - Project 3.b.i

	11. 'Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
	12. Document patient driven self-management goals in the medical record and review with patients at each visit.			In Process	Pass & Ongoing	N/A
	Enter Reviewer Comment					
	13. Follow up with referrals to community based programs to document participation and behavioral and health status changes.			In Process	Pass & Ongoing	N/A
	Enter Reviewer Comment					
	14. Develop and implement protocols for home blood pressure monitoring with follow up support.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
	15. Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
	16. Facilitate referrals to NYS Smoker's Quitline.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
	17. Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk			In Process	Pass & Ongoing	N/A
	Enter Reviewer Comment					
	18. Adopt strategies from the Million Hearts Campaign.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A

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Suffolk Care Collaborative - Project 3.b.i

	Enter Reviewer Comment					
	19. Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.			In Process	Pass & Ongoing	N/A
	Enter Reviewer Comment					
	20. Engage a majority (at least 80%) of primary care providers in this project.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
Total						**0.00**

Domain 3 Pay for Performance and Pay for Reporting			
AV Driving	**Measure**	**Reviewer Status**	**AVs Awarded**
	Aspirin Use	Pass & Ongoing	0.5
	P4R Measure DY3Q2		
	Discussion of Risks and Benefits of Aspirin Use	Pass & Ongoing	0.5
	P4R Measure DY3Q2		
	Controlling High Blood Pressure	Pass & Ongoing	1
	P4R Measure DY3Q2		
	Flu Shots for Adults Ages 18 – 64	Pass & Ongoing	1
	P4R Measure DY3Q2		

●	Health Literacy (QHL13, 14, and 16)	Pass & Ongoing	1
	P4R Measure DY3Q2		
●	Medical Assistance with Smoking and Tobacco Use Cessation - Advised to Quit	Pass & Ongoing	0.3333333
	P4R Measure DY3Q2		
●	Medical Assistance with Smoking and Tobacco Use Cessation - Discussed Cessation Medication	Pass & Ongoing	0.3333333
	P4R Measure DY3Q2		
●	Medical Assistance with Smoking and Tobacco Use Cessation - Discussed Cessation Strategies	Pass & Ongoing	0.3333333
	P4R Measure DY3Q2		
●	Statin Therapy for Patients with Cardiovascular Disease - Received Statin Therapy	Pass & Ongoing	0.5
	P4R Measure DY3Q2		
●	Statin Therapy for Patients with Cardiovascular Disease - Statin Adherence 80%	Pass & Ongoing	0.5
	P4R Measure DY3Q2		
●	Prevention Quality Indicator # 8 (Heart Failure) ±	Pass & Ongoing	1
	P4R Measure in DY3Q2		
●	Prevention Quality Indicator # 7 (HTN) ±	Pass & Ongoing	1

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Achievement Value (AV) Scorecard DY3, Q2 July 1, 2017 - September 30, 2017 (Payment Quarter)
Suffolk Care Collaborative - Project 3.b.i

P4R Measure DY3Q2	
Total	**8.00**

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Achievement Value (AV) Scorecard DY3, Q2 July 1, 2017 - September 30, 2017 (Payment Quarter)
Suffolk Care Collaborative - Project 3.c.i

Project Snapshot	
Project Domain	Clinical Improvement Projects (Domain 3)
Project ID	3.c.i
Project Title	Evidence-based strategies for disease management in high risk/affected populations. (adult only)

Payment Snapshot		
DY3, Q2 Payment Available	$	1,962,366
DY3, Q2 Payment Earned	$	1,962,366

3.c.i Scoresheet

Domain	Component	Review Status	AVs Available	Net AVs Awarded	Percentage AV	Domain Funding % (DY3)	Domain Funding % (DY3, Q2)	Payment Available ($)	Net Payment Earned ($)
Domain 1	Domain 1 Organizational	Complete	5.00	5.00	100%	40%	40%	784,946	784,946
	Project Implementation Speed	N/A	0.00	0.00	0%				
	Patient Engagement Speed	Complete	1.00	1.00	100%				
Domain 1 Subtotal			**6.00**	**6.00**	**100%**	**40%**	**40%**	**784,946**	**784,946**
Domain 3	Domain 3 Pay for Reporting (P4R)	Complete	6.00	6.00	100%	10%	60%	1,177,420	1,177,420
	Domain 3 Pay for Performance (P4P)		0.00	0.00	N/A	50%	0%	-	-
Domain 3 Subtotal			**6.00**	**6.00**	**100%**	**60%**	**60%**	**1,177,420**	**1,177,420**
Total		**Complete**	**12.00**	**12.00**	**100%**	**100%**	**100%**	**1,962,366**	**1,962,366**

Total Project 3.c.i AVs Awarded: 12 out of 12

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Domain 1 Project Milestones Project 3.c.i

AV Driving	Project Requirement and Metric/Deliverable	Required Due Date	Committed Due Date	Milestone Status	Reviewer Status	AVs Awarded
	Module 1 - Major risks to implementation and mitigation strategies	Ongoing	N/A	In Process	Pass & Ongoing	N/A

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Achievement Value (AV) Scorecard DY3, Q2 July 1, 2017 - September 30, 2017 (Payment Quarter)
Suffolk Care Collaborative - Project 3.c.i

	Enter Reviewer Comment					
	Module 2 - Project Implementation Speed	Ongoing	N/A	In Process	Pass & Ongoing	0.00
	Enter Reviewer Comment					
	Module 3 - Patient Engagement Speed	Ongoing	N/A	In Process	Pass & Ongoing	1
	Enter Reviewer Comment					
Total						**1.00**

Domain 1 Project Prescribed Milestones Project 3.c.i					
AV Driving	**Project Requirement and Metric/Deliverable**	**Committed Due Date**	**Milestone Status**	**Reviewer Status**	**AVs Awarded**
	1. Implement evidence-based best practices for disease management, specific to diabetes, in community and ambulatory care settings.			Pass & Ongoing	N/A
	Enter Reviewer Comment				
	2. Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment				
	3. Develop care coordination teams (including diabetes educators, nursing staff, behavioral health providers, pharmacy, community health workers, and Health Home care managers) to improve health literacy, patient self-efficacy, and patient self-management.	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment				
	4. Develop "hot spotting" strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.	3/31/2017	Completed	Pass & Complete	N/A

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Achievement Value (AV) Scorecard DY3, Q2 July 1, 2017 - September 30, 2017 (Payment Quarter)
Suffolk Care Collaborative - Project 3.c.i

	Enter Reviewer Comment				
	5. Ensure coordination with the Medicaid Managed Care organizations serving the target population.			Pass & Ongoing	N/A
	Enter Reviewer Comment				
	6. Use EHRs or other technical platforms to track all patients engaged in this project.	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment				
	7. Meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3 for EHR systems used by participating safety net providers.			Pass & Ongoing	N/A
	Enter Reviewer Comment				
Total					**0.00**

Domain 3 Pay for Performance and Pay for Reporting			
AV Driving	**Measure**	**Reviewer Status**	**AVs Awarded**
	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) ±	Pass & Ongoing	1
	P4R Measure in DY3Q2		
	Comprehensive Diabetes screening – All Four Tests (HbA1c, lipid profile, dilated eye exam, nephropathy monitor)	Pass & Ongoing	1
	P4R Measure in DY3Q2		
	Flu Shots for Adults Ages 18 – 64	Pass & Ongoing	1
	P4R Measure in DY3Q2		

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Achievement Value (AV) Scorecard DY3, Q2 July 1, 2017 - September 30, 2017 (Payment Quarter)
Suffolk Care Collaborative - Project 3.c.i

	Health Literacy (QHL13, 14, and 16)	Pass & Ongoing	1
	P4R Measure in DY3Q2		
	Medical Assistance with Smoking and Tobacco Use Cessation - Advised to Quit	Pass & Ongoing	0.3333333
	P4R Measure in DY3Q2		
	Medical Assistance with Smoking and Tobacco Use Cessation - Discussed Cessation Medication	Pass & Ongoing	0.3333333
	P4R Measure in DY3Q2		
	Medical Assistance with Smoking and Tobacco Use Cessation - Discussed Cessation Strategies	Pass & Ongoing	0.3333333
	P4R Measure in DY3Q2		
	Prevention Quality Indicator # 1 (DM Short term complication) ±	Pass & Ongoing	1
	P4R Measure in DY3Q2		
Total			**6.00**

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Achievement Value (AV) Scorecard DY3, Q2 July 1, 2017 - September 30, 2017 (Payment Quarter)
Suffolk Care Collaborative - Project 3.d.ii

Project Snapshot	
Project Domain	Clinical Improvement Projects (Domain 3)
Project ID	3.d.ii
Project Title	Expansion of asthma home-based self-management program

Payment Snapshot		
DY3, Q2 Payment Available	$	2,027,778
DY3, Q2 Payment Earned	$	1,774,306

3.d.ii Scoresheet

Domain	Component	Review Status	AVs Available	Net AVs Awarded	Percentage AV	Domain Funding % (DY3)	Domain Funding % (DY3, Q2)	Payment Available ($)	Net Payment Earned ($)
Domain 1	Domain 1 Organizational	Complete	5.00	5.00	100%	40%	40%	811,111	811,111
	Project Implementation Speed	N/A	0.00	0.00	0%				
	Patient Engagement Speed	Complete	1.00	1.00	100%				
Domain 1 Subtotal			**6.00**	**6.00**	**100%**	**40%**	**40%**	**811,111**	**811,111**
Domain 3	Domain 3 Pay for Reporting (P4R)	Complete	4.00	4.00	100%	10%	10%	202,778	202,778
	Domain 3 Pay for Performance (P4P)		4.00	3.00	75%	50%	50%	1,013,889	760,417
Domain 3 Subtotal			**8.00**	**7.00**	**88%**	**60%**	**60%**	**1,216,667**	**963,195**
Total		**Complete**	**14.00**	**13.00**	**93%**	**100%**	**100%**	**2,027,778**	**1,774,306**

Total Project 3.d.ii AVs Awarded: 13 out of 14

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Domain 1 Project Milestones Project 3.d.ii

AV Driving	Project Requirement and Metric/Deliverable	Required Due Date	Committed Due Date	Milestone Status	Reviewer Status	AVs Awarded
	Module 1 - Major risks to implementation and mitigation strategies	Ongoing	N/A	In Process	Pass & Ongoing	N/A

	Enter Reviewer Comment					
	Module 2 - Project Implementation Speed	3/31/2017	3/31/2017	Completed	Pass & Ongoing	0.00
	Module 3 - Patient Engagement Speed	Ongoing	N/A	In Process	Pass & Ongoing	1
	Enter Reviewer Comment					
Total						**1.00**

Domain 1 Project Prescribed Milestones Project 3.d.ii						
AV Driving	**Project Requirement and Metric/Deliverable**	**Required Due Date**	**Committed Due Date**	**Milestone Status**	**Reviewer Status**	**AVs Awarded**
	1. Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
	2. Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
	3. Develop and implement evidence-based asthma management guidelines.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					

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Achievement Value (AV) Scorecard DY3, Q2 July 1, 2017 - September 30, 2017 (Payment Quarter)
Suffolk Care Collaborative - Project 3.d.ii

●	4. Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
●	5. Ensure coordinated care for asthma patients includes social services and support.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
●	6. Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
●	7. Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
●	8. Use EHRs or other technical platforms to track all patients engaged in this project.	3/31/2017	3/31/2017	Completed	Pass & Complete	N/A
	Enter Reviewer Comment					
Total						**0.00**

Domain 3 Pay for Performance and Pay for Reporting			
AV Driving ●	**Measure**	**Reviewer Status**	**AVs Awarded**

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Achievement Value (AV) Scorecard DY3, Q2 July 1, 2017 - September 30, 2017 (Payment Quarter)
Suffolk Care Collaborative - Project 3.d.ii

●	Asthma Medication Ratio (5 – 64 Years)	Pass & Ongoing	1
	P4P Measure DY3Q2		
●	Medication Management for People with Asthma (5 - 64 years) - 50% of Treatment days covered	Fail	0
	P4P Measure DY3Q2		
●	Medication Management for People with Asthma (5 - 64 years) - 75% of Treatment days covered	Fail	0
	P4P Measure DY3Q2		
●	Pediatric Quality Indicator # 14 Pediatric Asthma ±	Pass & Ongoing	1
	P4P Measure DY3Q2		
●	Prevention Quality Indicator # 15 Younger Adult Asthma ±	Pass & Ongoing	1
	P4P Measure DY3Q2		
●	Asthma Medication Ratio (5 – 64 Years)	Pass & Ongoing	1
	P4R Measure DY3Q2		

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Achievement Value (AV) Scorecard DY3, Q2 July 1, 2017 - September 30, 2017 (Payment Quarter)
Suffolk Care Collaborative - Project 4.a.ii

Project Snapshot	
Project Domain	Domain 4: Population-wide Projects: New York's
Project ID	4.a.ii
Project Title	Prevent Substance Abuse and Other Mental, Emotional and Behavioral Disorders

Payment Snapshot		
DY3, Q2 Payment Available	$	1,308,244
DY3, Q2 Payment Earned	$	1,308,244

4.a.ii Scoresheet

Domain	Component	Review Status	AVs Available	Net AVs Awarded	Percentage AV	Domain Funding % (DY3)	Domain Funding % (DY3, Q2)	Payment Available ($)	Net Payment Earned ($)
Domain 1	Domain 1 Organizational	Complete	5.00	5.00	100%	40%	40%	523,298	523,298
	Project Implementation Speed	N/A	0.00	0.00	0%				
	Patient Engagement Speed	N/A	0.00	0.00	0%				
Domain 1 Subtotal			**5.00**	**5.00**	**100%**	**40%**	**40%**	**523,298**	**523,298**
Domain 4	Domain 4 Pay for Reporting (P4R)	Complete	11.00	11.00	100%	60%	60%	784,946	784,946
	Domain 4 Pay for Performance (P4P)	N/A	N/A	N/A	N/A	0%	0%	-	-
Domain 4 Subtotal			**11.00**	**11.00**	**100%**	**60%**	**60%**	**784,946**	**784,946**
Total		**Complete**	**16.00**	**16.00**	**100%**	**100%**	**100%**	**1,308,244**	**1,308,244**

Total Project 4.a.ii AVs Awarded: 16 out of 16

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Domain 4 Pay for Performance and Pay for Reporting Project 4.a.ii (all Milestones are P4R in DY2)			
AV Driving	**Measure**	**Reviewer Status**	**AVs Awarded**
	Age-adjusted preventable hospitalizations rate per 10,000 - Aged 18+ years – Ratio of Hispanics to White non-Hispanics	Pass & Ongoing	1

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Suffolk Care Collaborative - Project 4.a.ii

	Enter Reviewer Comment		
	Age-adjusted suicide death rate per 100,000	Pass & Ongoing	1
	Enter Reviewer Comment		
	Percentage of adults with health insurance - Aged 18- 64 years	Pass & Ongoing	1
	Enter Reviewer Comment		
	Percentage of premature death (before age 65 years)	Pass & Ongoing	1
	Enter Reviewer Comment		
	Percentage of premature death (before age 65 years) – Ratio of Black non-Hispanics to White non-Hispanics	Pass & Ongoing	1
	Enter Reviewer Comment		
	Percentage of premature death (before age 65 years) – Ratio of Hispanics to White non-Hispanics	Pass & Ongoing	1
	Enter Reviewer Comment		
	Age-adjusted percentage of adult binge drinking during the past month	Pass & Ongoing	1
	Enter Reviewer Comment		
	Age-adjusted percentage of adults who have a regular health care provider - Aged 18+ years	Pass & Ongoing	1
	Enter Reviewer Comment		

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Achievement Value (AV) Scorecard DY3, Q2 July 1, 2017 - September 30, 2017 (Payment Quarter)
Suffolk Care Collaborative - Project 4.a.ii

●	Age-adjusted percentage of adults with poor mental health for 14 or more days in the last month	Pass & Ongoing	1
	Enter Reviewer Comment		
●	Age-adjusted preventable hospitalizations rate per 10,000 - Aged 18+ years	Pass & Ongoing	1
	Enter Reviewer Comment		
●	Age-adjusted preventable hospitalizations rate per 10,000 - Aged 18+ years – Ratio of Black non-Hispanics to White non-Hispanics	Pass & Ongoing	1
	Enter Reviewer Comment		
Total			**11.00**

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Achievement Value (AV) Scorecard DY3, Q2 July 1, 2017 - September 30, 2017 (Payment Quarter)
Suffolk Care Collaborative - Project 4.b.ii

Project Snapshot	
Project Domain	Domain 4: Population-wide Projects: New York's
Project ID	4.b.ii
Project Title	Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings

Payment Snapshot		
DY3, Q2 Payment Available	$	1,112,007
DY3, Q2 Payment Earned	$	1,112,007

4.b.ii Scoresheet

Domain	Component	Review Status	AVs Available	Net AVs Awarded	Percentage AV	Domain Funding % (DY3)	Domain Funding % (DY3, Q2)	Payment Available ($)	Net Payment Earned ($)
Domain 1	Domain 1 Organizational	Complete	5.00	5.00	100%	40%	40%	444,803	444,803
	Project Implementation Speed	N/A	0.00	0.00	0%				
	Patient Engagement Speed	N/A	0.00	0.00	0%				
Domain 1 Subtotal			**5.00**	**5.00**	**100%**	**40%**	**40%**	**444,803**	**444,803**
Domain 4	Domain 4 Pay for Reporting (P4R)	Complete	17.00	17.00	100%	60%	60%	667,204	667,204
	Domain 4 Pay for Performance (P4P)	N/A	N/A	N/A	N/A	0%	0%	-	-
Domain 4 Subtotal			**17.00**	**17.00**	**100%**	**60%**	**60%**	**667,204**	**667,204**
Total		**Complete**	**22.00**	**22.00**	**100%**	**100%**	**100%**	**1,112,007**	**1,112,007**

Total Project 4.b.ii AVs Awarded: 22 out of 22

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Domain 4 Pay for Performance and Pay for Reporting

AV Driving	Measure	Reviewer Status	AVs Awarded
	Percentage of premature death (before age 65 years)	Pass & Ongoing	1

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Achievement Value (AV) Scorecard DY3, Q2 July 1, 2017 - September 30, 2017 (Payment Quarter)
Suffolk Care Collaborative - Project 4.b.ii

	Enter Reviewer Comment		
	Percentage of premature death (before age 65 years) – Ratio of Black non-Hispanics to White non-Hispanics	Pass & Ongoing	1
	Enter Reviewer Comment		
	Percentage of premature death (before age 65 years) – Ratio of Hispanics to White non-Hispanics	Pass & Ongoing	1
	Enter Reviewer Comment		
	Age-adjusted preventable hospitalizations rate per 10,000 - Aged 18+ years	Pass & Ongoing	1
	Enter Reviewer Comment		
	Age-adjusted preventable hospitalizations rate per 10,000 - Aged 18+ years – Ratio of Black non-Hispanics to White non-Hispanics	Pass & Ongoing	1
	Enter Reviewer Comment		
	Age-adjusted preventable hospitalizations rate per 10,000 - Aged 18+ years – Ratio of Hispanics to White non-Hispanics	Pass & Ongoing	1
	Enter Reviewer Comment		
	Percentage of adults with health insurance - Aged 18- 64 years	Pass & Ongoing	1
	Enter Reviewer Comment		
	Age-adjusted percentage of adults who have a regular health care provider - Aged 18+ years	Pass & Ongoing	1
	Enter Reviewer Comment		

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	Percentage of adults who are obese	Pass & Ongoing	1
	Enter Reviewer Comment		
	Percentage of children and adolescents who are obese	Pass & Ongoing	1
	Enter Reviewer Comment		
	Percentage of cigarette smoking among adults	Pass & Ongoing	1
	Enter Reviewer Comment		
	Percentage of adults who receive a colorectal cancer screening based on the most recent guidelines - Aged 50-75 years	Pass & Ongoing	1
	Enter Reviewer Comment		
	Asthma emergency department visit rate per 10,000	Pass & Ongoing	1
	Enter Reviewer Comment		
	Asthma emergency department visit rate per 10,000 - Aged 0-4 years	Pass & Ongoing	1
	Enter Reviewer Comment		
	Age-adjusted heart attack hospitalization rate per 10,000	Pass & Ongoing	1
	Enter Reviewer Comment		
	Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 6- 17 years	Pass & Ongoing	1

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Suffolk Care Collaborative - Project 4.b.ii

	Enter Reviewer Comment		
	Rate of hospitalizations for short-term complications of diabetes per 10,000 – Aged 18+ years	Pass & Ongoing	1
	Enter Reviewer Comment		
Total			**17.00**